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ABSTRACT

This document, prepared under the auspices of the Trilateral Initiative for North American Nursing, a professional organization of nursing, examines and compares nursing standards in Canada, Mexico, and the United States. The report focuses on first-level, general nurses and advanced or specialty practice nurses, and is organized in four parts: (1) education standards; (2) education program approval and accreditation; (3) licensure, registration and standards of practice; and (4) certification and licensure of specialty and advanced nursing practice. In each part, separate monographs describe the practices and standards for each country; following the monographs, a section titled "Similarities and Differences," summarizes the information in tabular form. The final section in each part is a brief list of recommendations. Many of the monographs contain references, notes, and appendixes. A final section contains general recommendations and an action plan for the next phase of the study. Appended are a glossary, a list of organizations and associations referred to in the text, a list of project participants and contact persons, and lists of reviewers and translators. (CH)

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The Trilateral Initiative for North American Nursing

An Assessment of North American Nursing

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The Trilateral Initiative for North American Nursing

An Assessment of North American Nursing

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The information and opinions expressed in this monograph are those of the participants of the Trilateral Initiative for North American Nursing and do not necessarily reflect the views of the Commission on Graduates of Foreign Nursing Schools.

Preface

The Trilateral Initiative for North American Nursing is a landmark, cooperative endeavor involving nursing professionals from Canada, Mexico and the United States. It is a broad-based assessment project with the short-term objective of gaining common understanding of nursing in the three countries, and the long-term goal of developing mutually acceptable standards for nursing so that ultimately health care is improved in Canada, Mexico and the United States.

The Trilateral Initiative is at once an ambitious and a modest undertaking. It is ambitious in the sense that it is the first effort by the North American nursing profession to comprehensively assess education and practice standards across the three countries. At the same time, the Trilateral can claim to have captured the status of nursing standards only at a discrete moment in time, mid-1995, when most of the research was completed. The dynamism of the nursing profession, coupled with a rapidly changing healthcare environment, are such that as we go to press with the monograph, some aspects of these standards are already undergoing significant change. Nonetheless, we hope that the work of the Trilateral Initiative will provide a knowledge base from which readers can address some of the vital issues facing the nursing profession across the continent as we approach the 21st century.

The participants in the Trilateral Initiative envision this monograph as a starting point for thoughtful dialogue among all those with a stake in the future of North American nursing. Ideally, the assessments and recommendations contained within the document will spur wide-ranging discussion and generate proposals from readers for further cooperative work. It is also our hope that this account of the nursing profession's collaborative process for assessing standards might provide other professions with a model for conducting appraisals of their own education and practice standards.

The Trilateral Initiative for North American Nursing began with a vision: a systematic assessment of North American nursing standards that would ultimately expand opportunities for nurses to collaborate on education, research and practice across borders. This vision was made a reality through the generous funding of the W.K. Kellogg Foundation, enabling participants in the Initiative to transform their ideas and energy into a tangible, useful product. We are grateful for the Foundation's keen understanding of, and support for, the potentially far-reaching impact of this intracontinental effort.

This document could not have been produced without the skills, wisdom and commitment of scores of individuals and organizations. It is difficult to find adequate words to thank the members of the four core work groups who, despite a thousand demands on their time, spent the better part of two years researching and writing the assessments that comprise this monograph. Throughout the process, they functioned as a superb and dedicated team. I am especially thankful to the facilitators of the core groups, Margaret (Pegi) Earle, Wendy McBride, Jennifer Bosma, Carolyn Hutcherson and Gail Tomblin Murphy, who coordinated the core group efforts as well as to Esther Gallegos and Sylvia de la Fuente Rocha, our colleagues in Mexico who served as contacts for the Trilateral Initiative in that country.

Many nursing organizations across the continent reviewed drafts of each chapter and offered their astute comments and suggestions. I am grateful to them, as well as to the organizations who provided invaluable translation services, not only for this document but also at meetings of Canadian, Mexican and United States participants. My appreciation also extends to the bilingual and trilingual readers who carefully read and analyzed the English, French and Spanish versions of the monograph to ensure consistency. Special thanks is due to the nine-member review panel of nursing experts who provided meticulous and discerning reviews of the monograph in its near-final form.

This project could not have succeeded without the foresight and commitment of the CGFNS Board of Trustees, who created an environment that placed high value on this effort. I am particularly grateful to Sylvia E. Hart, CGFNS President at the inception of the Trilateral Initiative, who has been a partner throughout the project.

Finally, the effective overall coordination of this project at the Commission on Graduates of Foreign Nursing Schools depended heavily on the skills and perseverance of Debbie Nevis, Catherine Davis, Marian Sandmaier, Chip Hurlburt, John Webster, and Anastasia Branco. I am deeply grateful to everyone involved in the Trilateral Initiative for North American Nursing for their wholehearted efforts on behalf of this project and for their unswerving belief in its value.

Virginia M. Maroun, MSN, RN
Executive Director
Commission on Graduates of Foreign Nursing Schools

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Note to the Reader

As you read this monograph, you may notice that certain terms as well as the names of organizations and associations specific to an individual country are unfamiliar to you. To facilitate your reading, specific aids have been made available within this document.

When the name of an organization or association is presented for the first time in each chapter, the full name is given in English followed, in parentheses, by the original language translation as well as the acronym. Thereafter, only the acronym appears.

As a further reference, a list of organizations and associations named in the monograph is provided on page 241, again written in English and followed, in parentheses, by the original language translation and the acronym.

The Glossary of Terms, page 243, provides an in-depth description of specific terms identified in the monograph as they are commonly used in Canada, Mexico and the United States.

Introduction

Project Scope and Goals

This document represents an historic turning point in the North American nursing profession. It is the first effort to systematically compare and contrast nursing standards across the continent, and to provide direction for mutual learning and identification of mutually acceptable standards for the profession in Canada, Mexico and the United States. The potential benefits of this unprecedented collegial endeavor are far-reaching: greatly increased opportunities for nurses to collaborate on education, research and practice across borders, ultimately leading to improved health care throughout the continent.

This assessment of standards is a response to significant challenges facing the nursing profession. Across borders, differences in standards and lack of information about these differences has caused confusion among nurses, employers, educators and regulators. As a result, nurses have not been able to take full advantage of employment and educational opportunities across the continent. Secondly, substantial shifts in the role of nurses in the health care systems of all three countries are motivating the profession to reassess, and in some cases modify, current standards, making the need for information exchange across the continent more vital than ever before. Third, economic and technological developments have led to the increased globalization of health care, which potentially offers nurses greater opportunities to provide services across borders. In this regard, a number of recent multinational agreements specifically encourage the professions to work together to assess education and practice standards and to determine the potential for working toward mutually acceptable standards.

This monograph provides a foundation for addressing these emerging challenges. It is the work of the Trilateral Initiative for North American Nursing, which was formed in 1994 by professionals and organizations representative of nursing in Canada, Mexico and the United States to further regional cooperation. Their assessment of standards comprehensively describes each country's standards for the nursing profession as of mid-1995 and illustrates the similarities and differences among the three countries along the following four dimensions:

- Education Standards
- Education Program Approval and Accreditation
- Licensure/Registration and Standards of Practice
- Certification or Licensure of Specialty and Advanced Nursing Practice

In addition, this monograph identifies trends in each of these areas and provides direction for future mutual learning and the development of mutually acceptable standards.

This report represents Phase One of the Trilateral Initiative for North American Nursing. It focuses on standards for first-level, general nurses and advanced or specialty practice nurses. While other levels of nursing practice are mentioned, they are not a focus of this assessment. Phase Two of the Trilateral Initiative for North American Nursing, which can be undertaken only after this report's recommendations are considered by the nursing profession, will involve implementation of this document's recommendations for a planning process to develop mutually acceptable standards.

The usefulness of this assessment is wide-ranging. It will provide nurse educators, researchers, administrators, employers and regulatory officials with information on the profession within their own countries, as well as answer questions about current levels of comparability and transferability of education and licensure/registration among the three countries. Ultimately, such insights may pave the way for improvements in education, accreditation, regulation and certification in all three countries, which in turn may improve the quality and availability of nursing care across the continent.

The benefits of this assessment process range beyond its impact on the nursing profession and on health care delivery. Nursing is only one of a number of North American professions affected by growing globalization and the consequent need to assess standards for education and practice. Other professions that are planning or engaged in a similar process of regional collaboration include medicine, dentistry, architecture, engineering and accounting, among others. With the aim of providing a concrete model for other professions who are embarking on a similar appraisal of standards, this monograph also describes in some detail the trilateral collaborative process that produced this assessment.

The Need for Continental Collaboration

Throughout North America, nursing is a rapidly changing profession. Accelerating efforts to develop or refine standards, vast changes in the health care systems, and new regional economic relationships have made the need for dialogue and cooperation among colleagues across borders increasingly crucial.

Nursing: A Changing Profession

Across the continent, the nursing profession is undergoing profound change. In Canada, health care cost-containment measures have led to a more competitive job market, which in turn has encouraged some Canadian nurses to seek employment opportunities abroad. Within Canada, the nursing profession has been steadily upgrading its education standards, and is in the process of adopting the baccalaureate degree as a minimum entry-level requirement for the profession. Canadian nursing leaders also continue to work toward defining a system of nursing specialty classification and to reach consensus on how nurses should be educated for specialty practice.

As of mid-1995, the Mexican nursing profession had limited programs of approval, accreditation and licensure/registration. While 95 percent of nurses have been educated at the secondary school level (that is, after nine years of education), standards are currently being drafted to provide for more nursing education programs at the post-secondary school level. Mexican nursing authorities are concerned about varying standards among existing nursing education programs, and have stated their interest in strengthening both their accreditation program and regulatory system for nurses.

In the United States, as health care delivery increasingly takes place in nursing homes, patients' homes, outpatient clinics and other community-based settings, more nurses will require skills and preparation that differ from those needed in hospitals. In response to these changes, nurse educators have begun to redesign nursing curricula to encompass this broader-based role for nurses. In addition, discussion continues about whether the baccalaureate degree should be required for entry to professional nursing practice.

A Changing Region

Recent trade agreements among North American countries have made it significantly easier for nurses to travel across borders on temporary work visas. In the first four years following passage of the 1990 United States-Canada Free Trade Agreement, the U.S. Immigration and Naturalization Service reported a nearly four-fold increase in the number of U.S. entries by Canadian-educated nurses holding temporary work visas. In 1994, the first year in which the North American Free Trade Agreement (NAFTA) took effect, the number of entries rose dramatically.

The increased travel of nursing professionals across borders presents potentially exciting new opportunities: additional education and employment opportunities for nurses themselves, and a broader range of nursing skills and experience to meet the needs of patients and health care institutions throughout the continent. While at present, these opportunities cannot be fully realized because of substantial differences in education and licensing regulations among the three countries, this situation may change. NAFTA, which explicitly seeks to "erase tariffs and other barriers to the movement of goods, services, and money" among North American countries, has specifically urged Canada, Mexico and the United States to develop mutually acceptable standards for licensing and certification of service providers in a number of professions, including the nursing profession. This development of mutually acceptable standards would reduce some barriers to increased employment opportunities and help to improve health care delivery.

NAFTA has assigned responsibility for this collaborative effort to the professions and their respective organizations. Already cognizant of the need for greater information sharing and planning across borders, the nursing profession in Canada, Mexico and the United States responded by jointly forming the Trilateral Initiative for North American Nursing, and thereby began an extended, wide-ranging dialogue about needs and requirements for increased regional cooperation.

The Trilateral Initiative for North American Nursing

Genesis of the Initiative

Even before the passage of NAFTA, education leaders and accreditation experts in Canada, Mexico and the United States had begun to discuss the need for intensified trilateral cooperation in light of the increasing mobility of students, scholars and professionals throughout North America. In January 1993, the Washington, DC-based Center for Quality Assurance in International Education (CQAIE) invited representatives from nursing and six other professions to meet in Tucson, Arizona for the first trilateral conference, *The Globalization of Higher Education and the Professions: The Mobility of Students, Scholars and Professionals.* At that meeting, participants agreed on the need for a major initiative dedicated to the promotion of common education and practice standards across key professions in North America through the development of linkages with professional associations in the three countries. It was decided that a second major conference would be held in Mexico the following year for the purpose of formulating more specific plans and goals.

The early commitment of nursing leaders to this initiative was apparent in a planning meeting held in New York City in April 1994, which was attended by representatives of 11 nursing and health organizations from Canada, Mexico and the United States. Sponsored by the U.S.-based Commission on Graduates of Foreign Nursing Schools (CGFNS), in collaboration with the National League for Nursing (NLN), this meeting gave representatives from each country the opportunity to present in some detail their current policies, standards, and trends in four areas: education, education program approval and accreditation, licensure/registration, and specialty practice. In the course of this unprecedented information exchange, many similarities and major differences across borders were identified. According to Dr. Sylvia E. Hart, then-president of CGFNS and chairperson of that meeting, the four key dimensions of the nursing profession that are the focus of this project were identified during those early discussions.

That meeting set the stage for the nursing profession's participation in the second major trilateral conference in May 1994, entitled *Globalization of Higher Education and the Professions: The Case of North America*, co-sponsored by the Center for Quality Assurance in International Education and the Mexican Ministry of Education, (Secretaría de Educación Pública, or SEP), in cooperation with the Association of Universities and Colleges of Canada. Attended by 500 representatives from major professions in Canada, Mexico and the United States, including more than 40 nursing professionals, the conference in Cancun, Mexico took a closer look at ways of pursuing the cooperation that NAFTA had by that time explicitly encouraged.

Following this conference, three specific goals were developed for the Trilateral Initiative for North American Nursing:

1. To encourage the development of mutually acceptable standards for education, education program approval and accreditation, licensure/registration, and specialty certification among Canada, Mexico and the United States in order to advance the nursing profession across North America;
2. To establish a viable, lasting network of key nursing organizations and professionals across North America;
3. To create a methodology that would demonstrate how other professional groups in the three countries could consult, develop goals and programs, and institute policies to increase cross-border cooperation.

Goal 1: Toward the Development of Mutually Acceptable Standards: Producing the Assessment

To begin working toward the first of these goals, encouraging the development of mutually acceptable standards, participants in the Trilateral Initiative agreed to conduct an assessment and produce a monograph that would describe North American nursing standards in the four identified areas: education, education program approval and accreditation, licensure/registration, and specialty practice. The document also would identify future trends and recommend for the nursing profession's consideration steps that the three countries could take toward the development of mutually acceptable standards.

The process of assembling a major document produced by several dozen authors, many of whom lived thousands of miles from each other, constituted a major challenge. How

could such an unwieldy project be coordinated? Who would be responsible for which tasks? How would communication flow across borders? With careful planning and effort, nursing leaders were able to create a workable process that permitted both substantial input from individuals and effective management of the whole. The following section describes that process in some detail, with the hope of providing a useful model for replication by other professions that also are seeking to assess their own standards as a basis for increasing regional cooperation.

Designing a Collaborative Process

To make the project both manageable and representative, Trilateral Initiative participants divided into four core groups, each of which was responsible for developing an assessment on one of the four topics under study. One group was charged with examining nursing education standards, another group focused on education program approval and accreditation, a third on licensure/registration and standards of practice, and a fourth on specialty certification. Each core group was composed of five to seven participants, one of whom was designated as facilitator of the group effort. Each group also solicited and relied upon the viewpoints of a number of other nursing professionals with expertise in the core group topic. The perspectives of these "contact persons" helped to ensure that each topic covered in the monograph would reflect a balanced view of the subject at hand.

Within each of the four core groups, members organized by country of origin into "mini-teams" of one to four people. Based on a content outline written and approved by the entire group, each country team wrote a descriptive account of that country's existing standards and practices as they related to the core group's topic. For example, the Mexican team from the core group on education standards developed a chapter identifying Mexico's standards for nursing education. Likewise, the Canadian and United States teams within that core group produced chapters on their respective country's education standards. Each chapter was then reviewed by the core group facilitator and other core group members, by other nursing professionals and nursing organizations, and by an outside editor.

Based on this review, each mini-team refined its respective chapter, circulated it to other interested parties, and resubmitted it to the editor for consolidation into a single draft monograph. After a review of this draft by each work group, the editor made recommended modifications and the monograph was forwarded to bilingual/trilingual readers with backgrounds in nursing who read the monograph for accuracy of translation. After their suggested changes were incorporated, the monograph was then forwarded to a nine-member review panel.

Selected with assistance from Trilateral participants, this review panel comprised internationally recognized experts in the nursing profession who had not been previously involved in the Initiative. After the panel reviewed the monograph for accuracy and objectivity, the editor incorporated reviewers' comments according to pre-established decision rules. The final result is this document, *An Assessment of North American Nursing*.

Managing the Project

Clearly, a project of this magnitude and complexity cannot run itself. The roles of oversight and coordination were taken on by the Commission on Graduates of Foreign Nursing Schools (CGFNS), which was founded in 1977 to help nurses educated abroad evaluate their eligibility for licensure and practice in the United States. The coordination tasks handled by CGFNS in the service of producing this assessment document included:

- Providing a central communications point for geographically distanced participants on all aspects of the project (see also "Collaborating Across Borders");
- Developing a Glossary of Terms, which was subject to multiple reviews and refinements by participants, to help ensure consistency of definitions among all four core groups and clarification to other readers of the monograph;
- Distributing background reference materials to participants;
- Serving as troubleshooter for the various logistical difficulties that can beset a multinational project;
- Compiling and synthesizing all chapters into a final document;
- Coordinating a multifaceted communications effort to disseminate information about the project and its findings on an ongoing basis;
- Conducting fundraising efforts to support project costs; and
- Continuing advocacy work for regional collaboration to build on this initial effort.

Collaborating Across Borders

Creating a joint project requires regular, thorough communication between and among members. This is often challenging enough in the best of circumstances; however,

when collaborators live in three different countries, in some cases speak different languages, and may never have even met face-to-face, communication guidelines become vital to the success of the project.

Project participants recognized early on that these various communication challenges needed to be addressed on two fronts: among participants themselves in order to accomplish the specific planning, assessment and writing tasks, and between CGFNS and all participants to ensure coordination of the project as a whole. To meet the first challenge, the facilitators for each core group assumed a number of essential responsibilities. Among other tasks, they made assignments to core group members, coordinated communication with their core group and contact persons, developed procedures for adding new members to the group, monitored participants' progress, coordinated their group's review of the glossary, and reviewed all written materials prior to submission. Facilitators also managed the budget for their group, and communicated with other facilitators to exchange ideas and ensure consistency in the documents under preparation.

To meet the second communication challenge, information exchange between CGFNS and participants, CGFNS produced a series of bimonthly information updates on the project that were sent regularly to all Initiative participants and other interested parties. Because these updates were designed as two-way communication conduits, many of them included reply forms for recipients to fill out on a number of topics, including suggestions for the content of chapters, additional organizations or individuals who might participate in the project, and possible funding sources. In addition, the updates kept participants informed about the overall progress of the project, participants' responses to various surveys on project issues, sources of assistance for communicating or information-gathering, and the status of funding efforts. CGFNS also made available Spanish-language versions of each update.

Because of the often prohibitive expense involved in face-to-face meetings across borders, international conference calls periodically were made to ensure ongoing communication among core group members themselves, and also between CGFNS and core group facilitators. Conference calls involving more than one language were arranged in one of two ways: by using the services of a private translation firm, which provided a translator to join in on the call, or by using a long distance telephone carrier's translation service. Participants also communicated via fax, electronic mail, and courier service.

While efforts were made to communicate through the most economical channels possible, the costs of international collaboration among several dozen participants were inevitably substantial. One continuing challenge of the project was to find ways to defray these considerable expenses, including those for conference calls, translation services, necessary travel, editing and secretarial support, photocopying and mailing. In some cases, participating organizations were able to include funds for the Trilateral Initiative in their budgets, and all provided significant in-kind services. However, even with this degree of support, it was necessary to seek additional funding from outside sources. Consequently, CGFNS submitted grant proposals to a number of foundations in late 1994 and early 1995.

In June 1995, the Trilateral Initiative received a $320,865 (U.S. dollars) grant from the W.K. Kellogg Foundation. The grant provided funding in support of participants' efforts to achieve the project goals.

Goal 2: Building a Network

To achieve the second goal of the project, the establishment of a "viable, lasting network of key nursing organizations and professionals across North America", the Trilateral Initiative made a concerted effort to involve nursing professionals from a wide variety of backgrounds, perspectives, organizational linkages and areas of expertise. To ensure this broad representation, CGFNS specifically asked the 1994 Trilateral Initiative conference attendees to suggest additional individuals and organizations for inclusion in the core groups, and also for names of nursing leaders and organizations who might provide consultation throughout the process, to make certain that the final documents would be representative of each country's nursing profession. By mid-1995, the Trilateral Initiative comprised more than 35 groups from professional nursing associations, educational institutions, and regulatory and policy-making agencies in Canada, Mexico and the United States.

Participants also have made a number of outreach efforts to the larger nursing community to build public awareness about the Initiative. Several participants have made presentations at meetings of professional organizations, including recent annual meetings of the Colegio Nacional de Enfermeras, A.C., and the American Academy of Nursing, as well as at a meeting of the Canadian Association of Latin American and Canadian Studies. Articles in leading professional journals will further disseminate the Initiative's findings to nursing leaders. Because of this planned, ongoing effort to inform and involve the trilateral nursing community in the project, the Trilateral Initiative is well-positioned to reach govern-

mental authorities, policy makers and nursing leaders who can help ensure that the assessment leads to collaborative action to improve standards for the benefit of consumers and nurses across North America.

Goal 3: Serving as a Model

A third goal of the Trilateral Initiative is to provide a model demonstrating how other North American professional groups can develop processes for appraising their own standards and recommending changes in accordance with NAFTA guidelines. As noted earlier, this monograph itself represents a major step toward this goal, for it details the specific structures and processes that were established to make possible the development of an assessment of standards. It is hoped that the nursing profession's assessment and the collaborative network that produced it will provide other professions with useful information about how to design a workable cooperative process, manage a multinational project, communicate across borders, and meet other challenges that inevitably arise from such cross-border endeavors.

Additional efforts have been made to communicate the Trilateral Initiative's experience to a wider audience. For example, the four core group facilitators and the project coordinator reported on the Trilateral Initiative's aims and progress, as well as on the practical aspects of organizing a cross-border project, at the 1995 annual meeting of the Council on Licensure, Enforcement and Regulation (CLEAR), whose attendees included regulatory experts from a broad spectrum of professions. Participants also have made themselves available to other professional leaders and associations who have expressed interest in learning more about the project.

Finally, Trilateral Initiative participants will prepare a process evaluation of their work, so that their experiences can shape and inform other professions' efforts. This evaluation will examine the strengths and weaknesses of the Trilateral Initiative for North American Nursing, discuss how various challenges have been addressed, and describe its success to date in meeting its goals. An evaluation of outcomes, that is, the degree to which the project's recommendations are ultimately translated into action, awaits completion of Phase Two of the Trilateral Initiative.

Governing Principles

The findings in this document are informed by a common set of governing principles regarding collaborative trilateral work on behalf of the North American nursing profession. These principles have both guided this first, assessment phase of the project, and will continue to serve and inform future phases of the Initiative. They are as follows:

- **Improved Health**
  The Trilateral Initiative facilitates the advancement of nursing education and practice in order to improve the health of North Americans by strengthening health care delivery in North America.
- **Systematic Assessment**
  The Trilateral Initiative supports and values sound methods for ongoing, systematic assessment of nursing education programs, program approval and accreditation, and for licensure/registration and certification of nurses in Canada, Mexico and the United States.
- **Shared Vision**
  The Trilateral Initiative recognizes and respects each nation's sovereignty while sharing and exploring common interests, concerns and issues that influence nursing and health care in North America.
- **International Linkages**
  The Trilateral Initiative ensures and enhances mutual exchange and enrichment among nurses and their organizations in the three North American countries.

A Foundation for Change

The assessment that follows represents a critical first step toward achieving insight on optimum standards for nursing education and practice among Canada, Mexico and the United States. Conceived in a spirit of mutuality, this document points the way toward still greater levels of cooperation as the Trilateral Initiative works toward the creation of a plan to develop mutually acceptable standards for the North American nursing profession, and, ultimately, toward more skilled, responsive and accessible health care throughout the continent.

Overview

Factors Shaping the Nursing Profession in Canada, Mexico and the United States

The development of nursing standards in each of the three North American countries can be fully understood only within the particular political, social, economic and geographical contexts of each country. Following is a table summarizing and comparing major factors that have shaped the nursing profession across North America, including form of government, geography, demographics, type of health care system, work force issues, and historical and societal issues and trends.

Factors Shaping the Nursing Profession in Canada, Mexico and the United States

Forms of Government

	Canada	Mexico	United States
Political Structure	▶ Canada is a confederation of ten provinces and two territories. ▶ Political power is distributed between the federal government and provincial/territorial governments.	▶ Mexico is a federal republic comprised of 31 states and a federal district. ▶ Political power is distributed between federal and state governments regarding internal affairs.	▶ The United States is a federal union with 50 state governments and five territories. ▶ Political power is distributed across the federal government and the state governments.
Constitution	▶ Canada's *Constitution Act* lays out the powers of the two levels of government. ▶ Anything not specified to the provinces lies with the federal government.	▶ Mexico's Constitution is the law governing the legal and political structure of the country, and the law regulating the practice of professionals, including health care professionals.	▶ U.S. Constitution assumes states' purview unless federal authority is specified. ▶ State action must yield when there is actual conflict with federal law.
Roots of Regulatory Function	▶ Established in provincial acts, based on a model of self-regulation. ▶ Mandatory registration is delegated to a non-governmental body comprised primarily of nurses.	▶ Established in the Constitution of 1945, Article 5. ▶ The Registry of the General Directorate of Professions grants a professional license or "cédula" based upon a diploma obtained from an official educational program.	▶ Established in state Nurse Practice Acts, which protect the title and scope of practice for individuals meeting minimum qualifications. ▶ Mandatory licensure is administered by state government boards comprised primarily of nurses.
Requirements	▶ Based on a model of professional self-regulation. Regulation includes educational requirements, a national examination, and title protection for nurses.	▶ Regulation includes educational requirements, a school-based examination, community service, and title protection for first and second level nurses.	▶ Regulation includes educational requirements, a national examination, and title protection for first and second level nurses.
Role of Professional Associations	▶ The responsibility for self-regulation is granted to the professional nursing association in provinces. ▶ Ontario has separated the roles of professional association and regulatory body.	▶ Colegio Nacional de Enfermeras, A.C. was founded in 1947, and as a college has legal status under the Education Law. ▶ The Colegio has proposed a certification process as a means of encouraging quality of care and professionalization of nursing. ▶ Associations have the capacity to regulate the profession.	▶ National and state nurses' associations propose legislation to regulate nursing education and practice.

Geography

	Canada	Mexico	United States
Geography	▶ Canada is the second largest country in the world. ▶ Canada is the most sparsely populated. ▶ Canada shares common borders with the United States.	▶ Mexico is the fifth largest country in the Americas. ▶ Mexico shares a common northern border with the United States.	▶ The United States is the fourth largest country in the world. Hawaii and Alaska are separated from the other 48 states by the Pacific Ocean and western Canada, respectively. ▶ The United States shares a common border with Canada to the north and Mexico to the south.

Demographics

	Canada	Mexico	United States
Language	▶ Both English and French are official languages. Linguistic duality is an integral part of Canadian society.	▶ Spanish is the official language. There are 56 ethnic groups that speak their own dialect.	▶ English is the predominant language spoken.
Population	▶ Approximately 27 million. ▶ Approximately 264,400 RN's, 83,749 RNA's/LPN's (3:1=RN:RNA/LPN). ▶ Ratio of 1 RN for every 103 residents. Ratio of 1 Nursing Personnel (RN & RNA/LPN) for every 78 residents.	▶ Approximately 81 million. ▶ Approximately 120,000 nurses (1:6=professional: technical). ▶ Ratio of 1 nurse per 7100 residents.	▶ Approximately 261 million. ▶ Approximately 2.8 million licensed nurses (3:1=RN:PN). ▶ Ratio of 1 nurse for every 90 residents.

Health Care System

	Canada	Mexico	United States
Health Care System	▶ The *Canada Health Act* (1984) specifies five principles/national standards that provincial/territorial health departments must respect to receive federal funding for health: public adminstration, accessibility, comprehensiveness, universality and portability. These five principles are the framework for health care delivery in Canada. *(continued)*	▶ The National Health System, coordinated by the Health Secretariat, consists of public, private and social programs, and provides 94% of the health services. ▶ Employer-paid private and government-sponsored (social) programs generally provide higher quality of care than public programs.	▶ Most United States citizens purchase or receive private health insurance through their employer. ▶ The federal Medicare program provides payment for care to the elderly and the federal Medicaid program provides payment for care to the poor and disabled.

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Health Care System *(Continued)*

	Canada	Mexico	United States
Health Care System *(continued)*	▶ The *Canada Health Act* provides that the federal government can deduct the value of services covered by the Act that are provided by the private sector.		
Financing	▶ The costs of the health program are shared between the federal and provincial governments. ▶ The federal government transfers funding to the provincial and territorial governments based on a formula that considers, among other things, the population and economic base of the province. ▶ The cost of providing health care to Canada's aboriginal population is a federal/ territorial responsibility.	▶ Financed by contribution from the federal government, employers and employees.	▶ Private health insurance is primarily financed through the employer with some contribution from the employee. Medicare is financed through the federal government. Medicaid costs are shared between federal and state governments.

Work Force Issues

	Canada	Mexico	United States
Labor	▶ Union membership varies among provinces from 55% to 95%.	▶ Nurses who work in public institutions are part of the union that holds a contract with that institution.	▶ About 10% of nurses are unionized.
Gender	▶ Predominantly female.	▶ Predominantly female.	▶ Predominantly female.

Historical and Societal Issues and Trends

	Canada	Mexico	United States
Emergence of Nursing	▶ Professional associations have played a key role in self-regulation of nursing. ▶ Other factors shaping nursing include the role of women in the workplace, societal and cultural perceptions about nursing, and health care reform.	▶ During wartimes in the 1840's and early 1900's, the role of the nurse emerged and training for career nursing began. ▶ In 1945, nursing was recognized as a profession. Autonomous nursing schools were established.	▶ Physicians obtained licensure first, thus establishing by law and by custom an essentially limitless scope for physician practice. ▶ Wartime stimulated the upward mobility of women; laws were passed to ensure preparation of nurses in adequate numbers for the military and civilian needs.

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Part One

Standards of Nursing Education in Canada, Mexico and the United States

The following section describes and compares standards of nursing education in the three North American countries for programs that prepare beginning nurses for entry into practice. While the focus is on registered nursing, these assessments examine different levels of educational programs that prepare nurses for initial practice, a situation that differs from other professions that have a single point of entry. Such comparative information on standards is vital because while each country's standards lay the foundation for practice, programs may be developed somewhat differently in the individual countries.

Following chapters on the history, current status and future projections for the standards of nursing education in each country, major similarities and differences in educational standards in Canada, Mexico and the United States are presented, focusing on governmental regulatory authority; role of the beginning nurse; content of education standards; programs and entrance requirements; and emerging trends and issues. Part One closes with recommendations for ongoing processes to facilitate further collaborative action and mutual learning.

Standards of Nursing Education in Canada

Margaret (Pegi) Earle, RN, BN, MScN
Canadian Nurses Association

Penny Ericson, RN, BSN, MScN
University of New Brunswick
Fredericton, New Brunswick

Patricia Kirkby, RN, BScN, MA
Fanshawe College
London, Ontario

Patricia Robinson, RN, BSN, MSc(N)
Malaspina University College
Nanaimo, British Columbia

Executive Summary

In Canada, most provincial nursing associations have had regulatory authority for setting minimum standards of nursing education since the early 1900's. This chapter describes the three models of nursing education standards currently in use across the country and the anticipated changes to the models and content of standards in the next ten years. The process of standards development and revision is also explained.

Although the vast majority of entry level registered nurses are currently prepared in diploma nursing programs, entry level education is increasingly moving to the baccalaureate degree in nursing programs. The similarities and differences between both programs are briefly described. Trends influencing this move to university preparation for beginning registered nurses in Canada are highlighted.

The challenges and issues emerging in Canada in relation to setting standards for nursing education and the regulation of those standards in the near future are also identified. Finally, the potential for resolution of differences in education standards between Canada, Mexico, and the United States is analyzed.

Historical Overview of the Origin and Evolution of Nursing Education Standards

In Canada, most provincial nursing associations have had regulatory authority for setting minimum standards of nursing education since the early 1900's. As early as the 1920's, the national nursing association and the provincial nursing associations were concerned about the inadequacies inherent in the "training of nurses", particularly in relation to the apprenticeship, hospital-based diploma program which was the predominant model of nursing education at the time.

These concerns prompted the national nursing association, i.e., the Canadian Nurses Association (CNA), and the Canadian Medical Association to commission a national study on nursing education. The resulting Weir Report (1932) recommended that nursing education should be moved from hospitals to the general education system and that university training programs for nurses should award degrees in nursing. CNA subsequently published a curriculum guide in 1936, followed by a supplement in 1940, to encourage programs to achieve educational autonomy from hospitals, and to promote a higher quality of nursing education programs across the country. Nursing education programs and provincial professional nursing associations used these early guidelines as a basis for the further development of nursing education in the

provinces. Thus, the CNA guidelines were the beginning of standardization of nursing education in Canada.

It was not until the early 1970's, when Weir's recommendations were supported by a national Royal Commission on Health Services (Hall, 1964) and subsequent provincial studies of post-secondary education and health care (1965-1974), that university Baccalaureate in Nursing (BN) programs expanded across the country and diploma nursing education programs began to move from the hospital to the post-secondary college education system. Although a few hospital-based diploma programs remain today, they are educationally based rather than service oriented.

According to Irmajean Bajnok (1992), "the 1960's and 1970's were a period of rapid transformation in nursing education in terms of program content and context. Curricula in schools were revised to reflect the increasing scientific foundation of nursing practice and to eliminate the apprenticeship orientation of previous decades" (p. 404). This transformation gave rise to the development of national standards of nursing education for Canada by CNA. The CNA (1978) education standards were formulated using structure, process, and outcome criteria and were "optimal" versus "minimal" in nature. These standards were then used by most provincial nursing associations to develop standards for the assessment of nursing education programs at regular intervals (i.e., approval process), and to promote the development of higher quality nursing education programs.

In 1972, the Canadian Association of University Schools of Nursing (CAUSN) was recognized as the accrediting body for university nursing programs. CAUSN began development of a national accreditation system for basic BN education programs which was fully established by 1986. The major objective of the program was/is to ensure that BN programs prepare the quality of nurse required to deal effectively with existing and future health problems. The accreditation process established four major criteria categories which were based on criteria proposed by Dr. Moyra Allen (1977): (a) program relevance to societal health trends, (b) accountability to client, (c) relatedness of program parts in achieving program goals, and (d) uniqueness of a program in capitalizing on characteristics of its setting and resources. These accreditation standards have been adopted by a number of provincial associations/nursing education approval bodies as the basis for the assessment of BN programs for approval status (Nova Scotia, Newfoundland, Ontario).

Since 1990, two provincial nursing associations (British Columbia and Saskatchewan) and one governmental nursing education approval body (Ontario College Standards and Accreditation Council) have revised their standards for nursing education. The nursing associations have moved away from using the CNA standards model, which emphasizes program structure and educational processes, to a model that is outcome-focused. The latter approach specifies criteria and indicators for the curriculum plan, implementation of the plan in terms of student achievement, and the graduate outcomes of the program. The Northwest Territories Nursing Association is also developing its first standards for nursing education using the outcome-focus approach. These associations believe the outcome-focused criteria highlight the need for programs to be accountable for graduate outcomes which, in turn, emphasize the Associations' responsibility to ensure that graduates are able to meet the standards and competencies for nursing practice as registered nurses. Likewise, in Ontario, the standards of nursing education were revised to reflect 1990 changes in the College of Nurses of Ontario's (the provincial nursing regulatory body) standards of nursing practice.

Purpose of Education Standards

The purpose of education standards is to reasonably assure that programs produce graduates who are able to practice safely according to designated standards and competencies of nursing practice. It is notable that only graduates of programs that meet the prescribed education standards (or equivalent) are eligible to write the national nurse registration/licensure examination. Thus, prescribing and monitoring education standards is one way the profession demonstrates accountability to the public.

Current Status of Nursing Education Standards

Regulatory Authority

In Canada, constitutional authority for regulation of education and health rests with the ten provincial (Newfoundland, Nova Scotia, New Brunswick, Prince Edward Island, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia) and two territorial (Northwest Territories and Yukon Territory) governments. Consequently, mechanisms for regulating standards of nursing education rest with the provinces and territories. In seven of the ten provinces (Newfoundland, Nova Scotia, New Brunswick, Prince Edward Island, Manitoba, Saskatchewan, and British Columbia) and one territory (Northwest Territories) the professional nursing association has the authority to prescribe and monitor nursing education standards through nursing acts or in regulations authorized by the acts. In the remaining three

provinces (Alberta, Quebec, and Ontario), although the authority for nursing education regulation rests with external governmental bodies, the professional nursing associations and/or nursing regulatory body (in Ontario, the College of Nurses of Ontario) may participate in the educational regulatory process. The Northwest Territories Nursing Association only received authority for regulating nursing education in 1995, as it introduced its first nursing education program in 1994. The Yukon Territory does not have a basic nursing education program, nor standards of nursing education. The Canadian Nurses Association (CNA), a national federation of provincial and territorial nursing associations, has no regulatory role in setting standards. CNA, however, has provided leadership to the provincial associations in the development and improvement of standards for nursing education in the country.

Standard development for nursing education is usually under the leadership of the professional association. A committee structure with representatives from nursing practice, education, government and/or employers, and increasingly, consumers coordinates the development, implementation, and evaluation of the standards. In the development and evaluation phases, there is broad consultation with the nursing community. Standard implementation is the responsibility of the education program and is monitored through the approval/accreditation process.

Role of Beginning Nurse

The beginning nurse is prepared as a generalist able to work with individuals, families, and groups in acute care, long term care, continuing care, and community settings. In addition, beginning practitioners with baccalaureate preparation are prepared to work with the "community as client". The beginning nurse is able to assume four major roles: provider of care, coordinator of care, client advocate, and member of a profession. Beginning nurses also address all aspects of health, including promotion, prevention, maintenance, restoration, and palliation. Most provinces have identified generic competencies, which specify the minimal (as opposed to optimal) knowledge, skills, judgments, values, and attitudes required of an average beginning nurse. These competencies reflect provincial nursing practice standards and are usually subsumed within the standards of nursing education.

Level of Education for Entry to Nursing

Two types of education programs prepare entry level nurses in Canada: Diploma in Nursing Programs and Baccalaureate Degree in Nursing (BN) Programs. Currently, the vast majority of entry level practitioners (registered nurses) are prepared in Diploma Nursing Programs.

Most diploma programs are located in the post-secondary college education system. However, some hospital-based diploma programs still exist. Diploma programs range in length from 20 months (two years) to 36 months (three years). The admission requirements for diploma programs include the successful completion of Grade XII in the secondary school system (or equivalent) with a minimal overall average ranging from 60-65% (C^+ to B^-). All programs have specific course requirements, which usually include English or French (first language), sciences (chemistry and/or biology preferred) and mathematics.

All BN programs are located in universities (i.e., institutions of higher learning) or a university college and are at least four academic years in length. In Quebec, university programs are three, not four, academic years in length, since they require for admission the completion of a secondary school V diploma plus a two-year post-secondary college program. The vast majority of BN programs in Canada require completion of Grade XII secondary school diploma (or equivalent) with an overall average ranging from 60-70% (C^+ to B) for admission. Ontario university programs require six Ontario advanced credits, which is equivalent to Grade XIII. BN programs also have specific course requirements for admission, which often include English or French (first language), biology, chemistry, and mathematics. Saskatchewan and Newfoundland universities (one each) also require successful completion of a pre-nursing, university-based year of study for admission to its BN programs. Only one university in Canada (McGill University) offers a basic nursing program leading to a master's degree for university graduates holding a Bachelor of Arts or Bachelor of Science degree.

It should be noted that nursing programs (both Diploma and BN) have always attracted highly qualified applicants. Thus, admission is competitive and successful candidates generally surpass the minimal standards for admission. For example, one BN program has a 70 percent admission requirement but the Grade XII secondary school class average was 78 percent for admission.

Increasingly, basic nursing education is moving to university preparation leading to a baccalaureate degree in nursing (either BN or BScN). In 1982, the Alberta Association of Registered Nurses and the CNA, followed by all other provincial and territorial nurses associations, adopted the position that by the year 2000, the minimal education requirement for entry into the practice of nursing should be successful completion of a baccalaureate degree in nursing. Three provinces, Nova Scotia, New Brunswick and Prince Edward Island, will meet the year 2000 target date for BN preparation for all entry level nurses. Although significant progress is being made in achieving the position in most other provinces (especially

in British Columbia, Alberta, Manitoba and Newfoundland), the year 2000 target date will not be met in all provinces or territories. In particular, two provinces (Ontario and Quebec), which prepare the largest number of entry level practitioners in Canada, will not meet the target date. Two educational delivery models are evolving in response to the trend toward degree preparation for entry to practice: (a) expansion of existing university BN programs and (b) development of collaborative linkages among universities, colleges/hospitals, and clinical agencies to deliver BN programs. The collaborative linkages combine the existing resources of baccalaureate and diploma programs in the delivery of new BN programs. In Canada, in 1994, there were 109 diploma programs and 26 BN (basic/generic) programs (CNA, 1995b).

Main Elements of Education Standards

Education standards are written from a broad perspective to allow for the diversity of health care provision required in a country that is vast, decentralized, and ethnically and culturally varied; includes large rural and urban populations; is affected by different health determinants (such as poverty, geography, housing, etc.); and is served by a variety of health care providers. There are three main models and/or approaches to nursing education standards in Canada: the structure, process, and outcome model; the outcome-focused model; and the accreditation model.

Structure, process, and outcome model. This model identifies the three types of standards and criteria that programs are expected to meet. Structure criteria focus on the essential organizational, human, and material support systems necessary to provide a nursing education program and how these interface with the education and health care systems. Some examples include organizational relationships with the educational institution, contractual relationships with affiliating clinical sites, adequacy of resources (facilities, clinical, support services), faculty numbers and qualifications. Process criteria focus on the effectiveness of the curriculum in providing students with the learning experiences required to develop professional competencies. For example, philosophy, objectives, conceptual framework, and curriculum content are evaluated specifically in relation to standards and competencies of practice, relationship between theory and practice experiences, responsiveness to trends that impact on health needs, and evaluation processes. Outcome criteria focus on the success of the program graduates: for example, graduate performance on national registration examinations and employer and graduate evaluation of readiness to meet nursing practice standards. The structure, process, and outcome model is criticized for focusing on the teaching-learning environment (structure/process) rather than on the learning that takes place (outcome).

Outcome-focused model. This model focuses on the ability of the education program to prepare graduates to meet the standards and competencies for nursing practice. Three broad criteria are specified: program curriculum, students and graduates. Indicators are identified to provide guidance in interpreting each criterion. The indicators for the curriculum criterion focus on goals and objectives, learning experiences and student evaluation methods. The curriculum must also reflect the province's practice standards and beginning nurse competencies.

The indicators for the student criterion address admission and promotion requirements. The indicators for the graduate criterion focus on the graduate's ability to meet program goals and the requirements for practice as a registered nurse. This model focuses on the student learning that takes place rather than on the teaching-learning environment.

Accreditation model. This model, developed by CAUSN, has been adopted by some regulatory bodies to guide the development, implementation, and evaluation of BN programs. Of course, the model is also used for its primary purpose, the voluntary accreditation of BN programs. The CAUSN (1995) model has four criteria:

1. Accountability: the extent to which the program teaches the student that the primary responsibility in nursing is to the client; that is, community, group, family, individual.
2. Relatedness: the extent to which the components of a program support and build on other parts, thereby promoting or negating the achievement of goals. The components are curriculum, the teaching of nursing, research, clinical practice and professional activities and administration. This quality is a measure of internal consistency.
3. Relevance: the extent to which the mission and goals of a program reflect a response to the major trends in society that impact on the health needs, present and future, of the larger community.
4. Uniqueness: the extent to which a program capitalizes on the unique characteristics of its resources (faculty, community values, financial support) within its particular setting (p. 2).

By moving beyond minimal standards to expectations of excellence, these criteria are intended to reassure the public about program quality, i.e., they are beyond minimal standards and relate to excellence.

Although provincial models or approaches may differ, nursing education standards across provinces are more similar than different.

Impact of Education Standards

Educational standards have a significant influence on the development and maintenance of the highest possible calibre of education. They are used by professional associations and faculty to support curriculum changes in response to trends in health, health care delivery and nursing, as well as to support funding requirements related to faculty, student placements and learning resources. Education standards and related standards of nursing practice and competency are also used by graduates, practicing nurses, and employers to determine the effectiveness of programs in preparing graduates to meet practice requirements and to identify priorities for continuing education.

Funding Sources For Nursing Education

The funding for health and post-secondary education in Canada is a partnership between the federal and provincial governments (i.e., funding is from public, not private, sources). The federal government contributes block funding to all provinces for post-secondary education and health through Established Program Financing. It also contributes to the general revenues of the economically disadvantaged provinces through Equalization Payments.

The vast majority of nursing education programs are funded by provincial government grants to the educational institution. Nursing programs are then funded by the institution under criteria similar to other educational programs. The higher costs associated with faculty clinical teaching models may result in proportionally higher funding for nursing education than for other programs in the institution. Although student tuition fees also contribute to program funding, it is readily acknowledged that they are not a significant source of revenue. Limited external funding is available for faculty research.

Historically, education and health have enjoyed acceptable levels of funding. However, due to the country's considerable debt resulting in a significant and annual decrease in both Established Program Financing and Equalization Payments to the provinces, funding for health and education has decreased and will continue to do so in the foreseeable future.

Ten-Year Projections for Standards of Nursing Education

Trends Influencing Standards

Many societal trends affect educational requirements for nursing. They include changes in the health of Canadians, changes in the health care delivery system, changes in the nature of nursing practice, and changes in the education system/process. A brief discussion of each of these trends follows.

Health of Canadians. In Canada there is an increasing life expectancy for both sexes and a declining birth rate: the population is aging. A shift has also occurred in major health problems from infectious diseases to chronic diseases. Moreover, the population is becoming increasingly multicultural, and nurses are developing practice strategies that are sensitive to diverse ethnic health needs. Finally, and perhaps most significantly, health is now defined and understood within the broader context of health-determining factors, such as income and education. Considerable discrepancy exists in the health of groups of people, such as aboriginal peoples and those living in isolated communities.

Health care delivery system. The Canadian health care system is characterized by perpetual change. Both governments and the public are placing increasing emphasis on the need for greater efficiency (e.g., population-based programs, downsizing/regionalization of services) and effectiveness (e.g., outcome-based assessments) of health care services. Nursing is advocating primary health care as the model of health care reform. The system is beginning to place less emphasis on costly curative services and more emphasis on health-oriented models of care delivery (e.g., health promotion, illness prevention). In addition, community-oriented services are expanding beyond the traditional foci of health promotion and illness prevention to include all aspects of health. More of the care traditionally provided in institutions is being delivered in community and home settings by both professional, non-professional, and family providers. Illness-oriented services are also changing. Acuity levels are higher than ever in hospitals. This fact, coupled with advances in diagnostic, therapeutic and information technologies, is resulting in more complex, highly specialized care delivered by a multiplicity of health care workers. The role of the consumer in the health care system is also changing from one of dependency to active participation. Some consumers are choosing to use alternative health treatments, such as herbal medicines and homeopathy, and governments are beginning to fund these therapies. Consumers are not only assuming responsibility in making choices about health and health services, but also in the health-planning and decision-making processes.

Nature of nursing practice. The content and context of nursing practice is also changing. The aging population, growth in multicultural populations, and the epidemiological shift to chronic illness have created new and different demands for nursing knowledge and services. In addi-

tion, changing consumer expectations and new ethical and legal imperatives are altering the nature of nursing's accountability to consumers.

Nursing in acute care environments is increasing in complexity, with role differentiation and specialization well established. The role of nurses in community settings and the home is expanding to include all aspects of health. Moreover, increasing emphasis on wellness, health promotion and client-centered care is creating new opportunities for nurses. More autonomous and expanded roles are evolving, including those of nurse practitioner, midwife, independent practitioner, and primary health care practitioner.

The proliferation of health care workers is causing role confusion between nursing and other nursing health care workers (licensed practical nurses, registered nursing assistants, auxiliary health personnel) and with other disciplines (physicians, social workers, etc.). In addition, nursing associations are currently refining the scope of nursing practice and attempting to resolve issues of overlap and shared roles within nursing (Registered Nurses, Registered Nursing Assistants, Licensed Practical Nurses, and Registered Psychiatric Nurses). A notable recent development is a National Nursing Competency Project, which will describe the shared and unique competencies and contexts of practice for all entry level nursing personnel in Canada in 1996 and 2001. The results of this project will, hopefully, identify new and/or the appropriate competencies for nurses and nursing personnel in the future.

Educational system/process. Educational institutions are also examining their efficiency and effectiveness in light of the socioeconomic and political trends. Nursing programs are responding to these trends with three major thrusts: redefinition of core curricula, reform of educational processes, and definition of educational outcomes.

Core curricula are being redefined and generally include:

1. Increased emphasis on determinants of health; all aspects of health (promotion, prevention, curative, maintenance, rehabilitation and palliation); evidence-based practice (research); community-based theory and experience, including primary health care.
2. Increased emphasis on the needs of the aged; ethnic groups; the chronically ill; deinstitutionalized populations; mental health consumers; issues of violence; and empowerment of the consumer.
3. Theory grounded in a variety of diverse practice learning opportunities and based on the standards and competencies of practice and research findings.
4. Use of new technologies for nursing care, communication, and information management.

Education processes are moving toward student- and consumer-centered versus teacher-centered philosophies and the development of skills for lifelong learning. Empowered students are viewed as partners in the educational process and faculty as resource persons and role models. As the average age of students increases, educational processes are increasingly directed by models of adult learning. The eclectic use of theories and models of nursing assist students to develop the breadth of knowledge and skills needed to make nursing judgments and to plan interventions. Emphasis is given to the development of critical thinking skills and a spirit of inquiry; independence, individuality, and leadership; and political activism.

Educational institutions are beginning to use non-traditional learning approaches including use of distance methodologies and recognition for prior non-traditional learning. The competency statements being developed through the National Nursing Competency Project will facilitate development of approaches for prior learning assessment. The widespread adoption of such approaches will increase access to and promote educational mobility through "bridging" and "laddering" models between programs.

The definition of educational outcomes is improving. Programs are developing multiple approaches for the definition and measurement of graduate competence. Programs also are embracing peer review and self-appraisal approaches in both faculty and program evaluation processes.

Emerging Regulatory Issues

Continued progress in the growth of BN programs for entry to practice preparation is leading regulatory bodies to examine policies and practices related to standards of nursing education and approval processes. Associations are questioning: Is there a need for standards of education for both the approval and accreditation process? Should the CAUSN national accreditation standards be used instead of provincial standards for monitoring BN programs?

New approaches to professional regulation are emerging, whereby licensing laws protect a title, such as RN, but not exclusive scope of practice. Thus, there will be increasing emphasis on competency, not credentials, for performance of professional practice. The implications of these new approaches to regulation of standards of basic education will emerge in the next decade.

With the shift to a consumer-focused, outcome-oriented health care system, the public will increasingly participate in professional regulatory processes. Although

consumers are already active participants in the development and monitoring of nursing education standards in some provinces, this trend will be embraced by all regulatory bodies in the future.

Anticipated Changes to the Elements and Content of Future Standards

Standards of education have been traditionally structure - process oriented. The validity of focusing on the teaching-learning environment versus student outcome criteria is being challenged. The need to establish more valid indexes for measuring education quality and graduate competency has been recognized by most regulatory bodies. Thus, careful examination of the outcome-focused standards model will take place in the next century. It is anticipated that this model will emerge as the dominant approach, will be continually refined, and will undergo more rigorous testing for reliability and validity.

As part of a recent national strategy on Quality and Effectiveness in Health Care (1993), a roundtable on professional education identified interrelated strategic issues for the education of professionals and volunteers in health services. It is anticipated that these five issues will guide the development of future standards and curricula for nursing education:

1. Consumer Focus: Educate professionals [nurses] to value and participate in a consumer-focused system.
2. Education of Health Professionals and Volunteers: Develop an education process built on a philosophy of lifelong learning, which educates professionals [nurses] with the knowledge, skills, and attitudes to enable consumers to attain, sustain, and retain health.
3. Leadership: Provide leadership for the education of health professionals [nurses] with respect to the context, content, and process of quality improvement.
4. Research: Support interdisciplinary, community-based research, issues analysis, and life long learning skills; approach research into the education of health professionals [nurses] in a systematic way to direct future education programs. Three perspectives should be emphasized: (a) student-based [nursing practice grounded in research findings, methodology, and critical appraisal]; (b) faculty-based [research in pedagogy and nursing practice]; and (c) community-based [human resource needs].
5. Role Determination: Define and validate roles in the context of interdisciplinary practice, provide for redistribution of power among all stakeholders and implementation of a primary health care model of education and practice of health professionals (National Strategy on Quality and Effectiveness in Health Care, 1993).

Process for Changing Standards

The process for ongoing revision and updating standards of education is the same as that described earlier for standard development. However, if a major change in standards is desired (for example, moving from diploma to BN degree preparation), the process is more complex. This process involves the development and operationalization of a strategic plan which is usually under the leadership of the professional association. In the development of the plan, broad consultation is sought from nursing practice, education, government, and employers. Consumers may be consulted at strategic points throughout the process. Support of key stakeholders, such as consumers, employers, and educational institutions, facilitates acceptance of a major change. Government support is essential to secure any related change in nursing regulations and/or to maintain or increase funding for education programs. The rationale for the change must be justifiable, demonstrating the relationship to the profession's primary accountability for public safety and quality nursing care.

Future Challenges in Standards Setting

With the recent adoption of both the Interprovincial Agreement on Internal Trade and the North American Free Trade Agreement, there is a growing need to facilitate the mobility of nurses across provinces and countries. Within Canada, the professional associations are striving to attain a common educational preparation for entry to the profession (Baccalaureate Degree in Nursing) and, in cooperation with the regulatory nursing bodies, agreement on "reality-based" competency statements and contexts of practice for beginning nurses. Both of these developments are designed to promote national standardization versus provincial differentiation of standards. These developments will provide a foundation for decisions about registration of new graduates, consideration of licensure/educational equivalencies for out-of-province and out-of-country applicants, and the development of tools for prior learning assessment for placement in nursing programs and, perhaps, licensure.

Educational standards and credentials will always be important indicators of competence. However, in the future, nursing associations/regulatory bodies will be challenged to explore other, more flexible methods of determining competencies.

Potential for Resolution of Differences

There is a growing recognition that nurses are practicing in a global society. National and provincial nursing associations and nursing programs have developed partnerships with their colleagues in other countries. These international partnerships demonstrate a desire by Canadian nurses to establish networks and collaborative relationships across borders. Moreover, increasing numbers of Canadian nurses are seeking career opportunities in the global market. Thus, nurses increasingly recognize the need to develop collaborative international relationships to resolve differences in educational standards for licensure.

This trilateral project represents a first step in assessing the standards of nursing education in Mexico, the United States and Canada. Broad and general comparisons have been identified. More detailed information is needed on the nature of nursing education programs and standards in both Mexico and the United States, in order to make more definitive comparisons with Canada's standards.

Small differences that do not result in lowering standards or jeopardizing public safety (e.g., minor content/competency differences), may be resolved on presentation to individual provincial nursing associations/ regulatory bodies. In most cases, these bodies have committees which examine educational credentials and program standards in light of the legislative mandate.

Large differences, which may result in lowering licensing standards or jeopardizing the standards of nursing practice (e.g., BN versus Diploma preparation for licensure), will be more difficult to resolve. The development of Canadian national nursing competencies and contexts for practice, if embraced by the regulatory bodies in legislation, may be used to determine licensure/educational equivalency in the future. These competency statements may also be used to assess prior learning for placement of foreign graduates in nursing programs, if necessary, to attain provincial educational standards. However, the current use of prior learning assessment is in its infancy and therefore, its use in provincial regulatory processes will emerge in the near future.

As previously discussed, Canadian nursing education is regulated by each of the ten provinces and two territories; no single, national regulatory authority governs nursing education. Thus, all provincial/territorial professional nursing associations/nursing regulatory bodies are key stakeholders and must participate in processes or strategies to foster "harmonization" of standards of nursing education among trilateral partners. Therefore, it is recommended that CNA take a lead role in Canada (among the ten provinces and two territories) to establish a consultative process whereby:

(a) the provincial/territorial professional and regulatory nursing organizations may analyze the results of this assessment; and

(b) based on the analysis, develop agreement on future processes to move toward mutually acceptable nursing education standards among the Canadian provinces/territories, the United States and Mexico.

The standards of nursing education in Canada are high. Moreover, these standards are changing in order to prepare beginning practitioners of nursing to meet the challenges of health care delivery in the next century. Canadian nurses look forward to collaborating with their colleagues in Mexico and the United States on the resolution of significant differences in education standards in order to promote high quality nursing practice across borders.

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Standards of Nursing Education in Mexico

Lic. Ma. de Jesús Elena Velázquez G.
Asociación Mexicana de Licenciados en Enfermería

Lic. Esther C. Gallegos
Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería

Lic. Irma J. Gómez Flores
Colegio Nacional de Enfermeras, A.C.

Executive Summary

Taking into consideration the social, economic and political development of Mexico and the creation of health care institutions, several methods for the preparation of nursing personnel can be identified. In analyzing those developments that have taken place since the turn of the century, at least three stages of the National Health System can be identified. These developments have determined the evolution of nursing in Mexico.

First Stage (1905-1940)

The nursing profession in Mexico originated early in the 20th century. The 1917 Political Constitution of Mexico provides that health care is an obligation linked to a labor relationship. Nursing became a formal profession following the opening of the first nursing school at Mexico City's General Hospital in 1905. Nursing programs were first offered at hospitals. Physicians were in charge of determining the duration of the program, the curricula and the admission requirements. Subsequently, the medical schools accredited those nursing schools and their curricula. Nursing schools were opened to train women in the care of patients as prescribed by physicians.

Second Stage (1940-1982)

This is known as the modern era of health care in Mexico and corresponds with the industrialization period of the country. Large hospitals and specialty institutes were built and the social security system was implemented in an effort to protect the health of workers and their families. Consequently, the demand for nursing personnel was high and numerous schools were opened. Those schools were incorporated to universities or the Public Education Secretariat (Secretaría de Educación Pública, or SEP), which in turn set somewhat uniform standards for the duration of the studies, the curricula and the admission and graduation requirements. Auxiliary nurses were also acknowledged as part of the nursing profession. To date, auxiliary nurses are trained at hospitals and health centers, though their training has undergone considerable variation.

The Mexican Nurses Association (Asociación Mexicana de Enfermeras, or AME) was created in 1947 with one of its goals being "to foster the educational development (of nurses) and improve the patient's care". Another goal of the AME was to set the minimum standards for nursing education. A proposal was drafted for this purpose, but was never finalized. AME became the National College of Nurses (Colegio Nacional de Enfermeras, or CNE) in 1966. In 1967, the CNE spon-

sored the creation of the National Association of Nursing Schools (Asociación Nacional de Escuelas de Enfermería) which became the National Federation of Associations of Nursing Schools (Federación Nacional de Asociaciones de Escuelas de Enfermería, or FENAFEE) in 1980. The first nursing instructors began to be trained in 1952 by the Pan-American Health Organization and the National School of Nursing and Obstetrics (Escuela Nacional de Enfermería y Obstetricia).

Third Stage (1982-1994)

Several legal and administrative changes resulting from Mexico's economic and political crisis took place during this period. The population increase and migration from rural areas to the cities resulted in massive urban concentrations lacking basic services. The Mexican government responded by encouraging the expansion of basic services, including health care. However, this was seen as an opportunity to hire untrained personnel to perform nursing functions.

The Interinstitutional Commission for the Preparation of Health Care Resources (Comisión Interinstitucional para la Formación de Recursos Humanos para la Salud, or CIFRHS) was created in 1983 to upgrade the training of personnel to meet the needs of the population and the priority programs of the National Health Care System. The design of the basic standards for nursing education was the responsibility of the Commission's nursing work group. Those standards identified the educational system structure but did not include any assessment criteria. Unfortunately, the standards did not became official and thus were not followed by the vast majority of nursing schools.

As a member of the International Council of Nurses (ICN), the CNE joined the project for the worldwide regulation of the nursing profession (1988-1994). Mexico's nursing needs were then identified. The CNE conducted a similar project on its own in order to draft the Nursing Training and Practice Regulation. The proposal derived from these efforts is pending legislation.

The proposal indicates that education is regulated by the federal and state authorities; that is, the General Professions Directorate (Dirección General de Profesiones, or DGP), the SEP, the universities and the National Association of Universities and Higher Education Institutes (Asociación Nacional de Universidades e Instituciones de Educación Superior, or ANUIES). The latter has concentrated its activities on the assessment of higher education. However, universities in this country, through their autonomy, determine the regulations imposed on curricula, the faculty, the student population and the necessary resources.

Once students complete the nursing program and receive their degree and license (cédula), they are not required to take any continuing education courses (contrary to the requirement for other professions).

The nursing standards will be influenced in the future by such developments as the North American Free Trade Agreement (NAFTA), Mexico's economic challenges, and the social and economic policies to be implemented by the government. The effects of these developments will be seen on the population's poverty levels, transitional epidemiological profiles, social programs, structural changes in the health care systems and higher education policies. Also impacted will be the nursing profession where some independent professional practice is being visualized.

Nursing standards will also be affected by the proposals of nurses, education and health care institutions, nursing colleges and associations, and other entities. Some of these proposals and related activities include:

- Regulations for nursing education and professional practice drafted by the CNE.
- The National Nursing Accreditation and Certification System (Sistema Nacional para la Acreditación y la Certificación de Enfermería, or SNACE), created by CNE in January 1994. The System has worked on these issues in Mexico and, under the framework of the NAFTA treaty, with its counterparts in Canada and the United States.
- A proposal for nursing institutes and curricula accreditation at both the technical and baccalaureate levels. This proposal has been promoted by FENAFEE.
- The National Nursing Interinstitutional Commission (Comisión Interinstitucional Nacional de Enfermería) and CIFRHS, both under the auspices of the Public Health Ministry, working on the accreditation system of educational institutions and their curricula.
- Recommendations for the mutual validation of licenses and certificates among Canada, Mexico and the United States, drafted by the Mexican Committee for the International Practice of Nursing (Comité Mexicano para la Practica Internacional de Enfermería, or COMPIE) created by the General Direction on Professions for the Public Education Ministry (Dirección General de Profesiones de la Secretaría de Educación Pública, or DGP-SEP).
- The Professional Quality Examination in Nursing.

The elements and content of the standards have been identified and are related to: the social importance of the profession, the need to reinforce the dominance of the profession, the transformation of the education process from "informational" to "formational", the demanding

nature of services, the responsibility of the educational sector for preparing and updating nurses, and the importance of the expansion of roles, areas and circumstances in which future graduates will work.

The main challenge will be to unite around shared interests since the standards process is a priority not only for Mexico's nursing profession but also for that of Canada and the United States.

Historical Overview of the Origin and Evolution of Nursing Education Standards

The lack of official nursing education standards applied across the Mexican Republic does not mean that the preparation of nurses has not been regulated. Standards have been set by the institutions in charge of preparing nurses. Considering the social and economic evolution of Mexico, the creation of health care institutions and the development of the nursing profession, various provisions for the preparation of nurses can be identified. In analyzing the developments and the social and political environment of Mexico from 1900 to date (Soberón y Valdés Olmedo, 1994), three stages can be identified in the National Health System that have been determinants in the development of the nursing profession.

First Stage

Nursing emerged as a profession early in the 20th century when health care became institutionalized. In 1917, health care became an obligation linked to a labor relationship as provided for in Mexico's Political Constitution. The Public Assistance Secretariat (Secretaría de Asistencia Pública), which was created sometime between 1917 and the early 1940's, was responsible for providing health care services for the Mexican population and for expanding the hospital infrastructure.

Nurses' education became formal with the opening of the first nursing school at Mexico City's General Hospital in 1905. However, 1907 marked the beginning of the formal functioning of this school with a regular student population. Physicians were in charge of determining the duration of the education, the curriculum and the admission requirements. Nursing programs were first offered at hospitals, but medical schools eventually validated the curricula. The schools were to prepare physicians' aides who were capable of providing the treatment physicians prescribed to hospitalized patients.

Nursing schools that opened between 1902 and 1940 conformed to the standards set by hospitals in terms of their academic and administrative organization. Since schools were part of hospitals, most of the students "learned by doing". Those schools linked to a school of medicine had an indirect relationship with the state universities to which the schools belonged (Martínez, Latapí, Hernández & Rodríguez, 1993).

Second Stage

The period between 1940 and 1982 is known as the modern stage of health care in Mexico and coincides with the industrialization of the country. Large hospitals, specialty institutes and the social security system were created to provide health care services for workers and their families. The demand for nursing personnel to meet the health care needs at those hospitals was rather high. However, the minimal response from the educational sector spurred the development of large numbers of nursing schools which were created to meet the specific needs of medium and high speciality hospitals. Those schools were incorporated by universities[1] or the Public Education Secretariat (Secretaría de Educación Pública, or SEP)[2] which defined in a more or less uniform manner the duration of studies, the curriculum based on the medical model, and the admission and graduation requirements. The "auxiliary nurse" was recognized as part of the nursing profession during this period. The training of auxiliary nurses (nursing assistants) varied widely. The Public Health Secretariat (Secretaría de la Salud Pública, or SSA), the hospitals and the health centers defined the admission requirements for auxiliary nurses in terms of education duration, curriculum and job description. The "good nurse" term was applied only to those nurses meeting the hospital's expectations, which meant that the areas of practice included in the curricula were of the utmost importance.

The concept of improving nursing education emerged when nurses created their own professional association. The Mexican Nurses Association (Asociación Mexicana de Enfermería, or AME) was created in 1947 with one of its purposes being "...to promote the educational progress (of nurses) as a means of improving care for the sick..." (Martínez, et al., 1993, p. 136). While the AME proposed some minimum standards for nursing schools in 1960 for the first time, no support was found outside the Association. The Association changed its name to the National College of Nurses (Colegio Nacional de Enfermería, or CNE) in 1966. One of the first and most important activities of the CNE was the revision of the nursing schools' curricula at the request of authorities from the National Autonomous University of Mexico (Universidad Nacional Autónoma de México, or UNAM). Another important factor in improving nursing education was the agreement established between the Pan- American Health Organization (PAHO) and UNAM's National School of Nursing and Obstetrics (Escuela Nacional de

Enfermería y Obstetricia de la UNAM) aimed at training nursing instructors beginning in 1952.

During this period, several associations and colleges were created in Mexico City and in most of the states of the Mexican Republic. Of great importance to nursing education was the creation of the National Association of Nursing Schools (Asociación Nacional de Escuelas de Enfermería) in 1967, which was organized into regional associations due to the increase in the number of nursing schools. Those associations coalesced under the National Federation of Nursing Schools Associations (Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería, or FENAFEE) in 1980 for the purpose of "contributing to the qualitative improvement of nursing education in Mexico". Nonetheless, no association or college undertook a process for the approval of standards for nursing education and practice.

Third Stage

The third stage is known as the "structural change stage" in Mexico's health care system and extends from 1984 through 1993. Basic legal and administrative changes took place during this stage. The population living in poverty and extreme poverty both in cities and in rural areas increased considerably. Urban margination became more evident during this time period. Having scarce or no services at all, the rural population migrated to the urban centers. Integral and multi-sector services, including some social content, were promoted by the government. The extension of health care services coverage led to the introduction of nursing personnel with very little training in nursing (Martinez, et al. 1993).

With the proliferation of nursing schools, general complaints emerged about the poor training received by nurses who studied at non-university schools. Therefore, some efforts were made to standardize nursing education. The first national effort made in this regard (and apparently the only one thus far) was the creation of the Interinstitutional Commission for the preparation of Health Care Resources (Comisión Interinstitucional para la Formación de Recursos Humanos para la Salud, or CIFRHS) by a presidential act in 1983. The purpose of this Commission was to establish close coordination between the education and health authorities to create health resources training programs based on objective knowledge of the population's needs and the priority programs of the National Health System (CIFRHS 1985). The Commission functioned through committees composed of representatives from the educational and health authorities and from the professional associations of the disciplines involved. One such committee was the Non-Physicians and Technical Professionals (Profesionistas Técnicos y No-Médicos) within which the ad hoc nursing groups formed and ultimately designed the *Basic Standards for Nursing Education*.

A number of factors influenced the decision to create basic standards. They included: a) the addition made to the fourth article of the Constitution which provided for the protection of health as a universal right; b) the increase in the basic education level of the population; c) the insufficient supply of nursing personnel both in terms of quality and quantity; d) the increase in the number of nursing schools with unqualified curricula and teaching staff; and e) the predominance of technical programs over university programs (an 8:1 ratio).

The purpose of the standards is to regulate the entire educational process, including the relationship between theory and practice as well as the relationship between participating individuals and institutions.

Process Standards Development

The nursing work group, as approved by CIFRHS, included representatives from the social security sector: the Mexican Social Security Institute (Instituto Mexicano del Seguro Social, or IMSS), the Social Security and Services Institute for Government Workers (Instituto de Seguridad Social al Servicio de los Trabajadores del Estado, or ISSSTE), the Family Integral Development System (Desarrollo Integral para la Familia, or DIF), the SSA that acted as the group coordinator, and other public and private health institutions. Representatives from nursing schools and professional associations also joined the group. Among those were the CNE and FENAFEE.

The final standards document was drafted following several meetings, individual and group work sessions, and presentation of progress reports to the work group and to the Non-Physicians and Technical Professionals Committee (Comité de Profesionistas Técnicos y No-Médicos).

General Focus and Content of Standards

The standards include guidelines for the training of baccalaureate nurses, technical nurses and auxiliary nurses. These include: a) the curriculum, with an emphasis on the social role of nursing and the profile of graduates; b) teaching staff training and functions; c) students, with an emphasis on admission requirements; d) resources, facilities, libraries and educational technology; e) community service; and f) evaluation of both the academic programs and learning levels.

The document includes an entire chapter on clinical standards, including site selection, supervision and evalu-

ation, and request and allotment, among others. Also included is a section on strategies for the implementation of the standards. The implementation proposal took into consideration the existing institutional structures and communication channels, and affirmed the autonomy of the educational and health sectors.

Despite the efforts made by the Public Health Secretary, who summoned the governors and health secretaries to disseminate and adopt the standards, and the offer from FENAFEE and the CNE to the Undersecretary of Higher Education and Scientific Research of the SEP to counsel the agencies responsible for granting authorizations for the opening of nursing schools, the standards did not become official nor were they adopted by a large number of schools.

The form and content of the *Basic Standards for Nursing Education* deal specifically with the structure of the nursing educational system; that is, the minimum criteria for nursing education. However, no criteria are included for the evaluation of each aspect.

In view of the above developments and their impact on health services and the nursing profession, the CNE deemed it important to participate in the worldwide project on the *Regulation of the Nursing Profession* of the International Council of Nurses (ICN). This project was based on the study conducted in over 100 countries that revealed the diversity of concepts, objectives, levels and development of the profession with standards different from those of other professions in the same country.

The CNE decided that one of its planning priorities as of 1988 would be the Nursing Regulation Project. To that end, it took part in three workshops-seminars organized by the ICN between 1988 and 1989 in Latin American countries (with the second being held in Mexico City). Following the first workshop-seminar, the CNE summoned nurses from the health care and educational services (members and non-members), from the 31 Colleges and State Affiliate Associations, FENAFEE and other associations to participate in the project and appoint representatives to the three national workshop-seminars. These were held in 1989 and 1990 for the purpose of making an assessment of the nursing situation and determining the elements necessary for regulation with an emphasis on raising professional standards.

Regulations Drafting Process

The drafting of the regulations was a long and complex process that stretched from 1990 through 1994. The task of joining the efforts and objectives of the professional organizations for a coordinated and integral job and for involving the maximum number of nurses required multiple meetings, an exchange of materials, analysis of drafts and counseling. All of those efforts concluded with CNE's 10th National Nursing Congress in October 1993. The Congress was centered on dissemination, discussion, feedback and consensus regarding the most relevant issues of nursing regulation. Some 1,200 male and female nurses attended the seminar and heard presentations from nursing specialists and other professionals, both from Mexico and other countries.

This regulation process is aimed at "raising the quality standards of nursing services for the ultimate goal of improving the living standards of Mexicans and promoting the development of the profession... both in terms of training and practice". The legal bases for this process are found in Mexico's Political Constitution, and the Laws on Health, Education, Professions and Labor.

The content of the regulations is based on a series of considerations characterizing the profession in its national and international context. It is divided into five chapters covering the following issues: general provisions, professional training, professional practice, social role, violations and penalties, and temporary articles. The legislative process needed for these regulations to become official is in the initial stages of development.

These regulations provide for the academic levels in nursing education (technical, baccalaureate and specialty). They also provide for continuous qualitative improvement in teaching and professional practice both inside and outside Mexico by means of the National System for Nursing Accreditation and Certification (Sistema Nacional para la Acreditación y Certificación de Enfermería, or SNACE).

Current Status of Nursing Education Standards

Regulatory Authority

The regulatory authority for nursing education is the same for all professions in the country at both the federal and state levels. According to Mexican law, the entities responsible for professional education are: a) the SEP through the Higher Education Under-Secretariat (Subsecretaría de Educación Superior) and the General Professions Directorate (Dirección General de Profesiones, or DGP), a federal agency; b) the State Education and Culture Secretariats (Secretarías Estatales de Educación y Cultura, or SEEC), which operate at the state level; and c) the universities and some higher education institutes that operate and evaluate the secondary education programs (high school and technical studies) as well as higher education programs (baccalaureate and graduate studies; General Law on Education, 1995).

Both the SEP and the universities may incorporate private schools to be responsible for the acknowledgement and granting of high school and university degrees. Incorporated private schools must offer the same curriculum as the university that incorporated them and must meet the academic standards established by that university.

The private and public higher education institutions have united under the National Association of Universities and Higher Education Institutes (Asociación Nacional de Universidades e Instituciones de Educación Superior, or ANUIES). This association is a decentralized entity that has influenced the standardization of higher education, including nursing education. An example of this standardization is the number of academic credits[3] required per educational level (the baccalaureate level requires between 350 and 450 credits; Barrón, 1982). Deans or directors of universities and higher education institutes represent their institutions in ANUIES, and endorse any agreements reached. While these agreements have no legal value, they do represent a moral commitment. The SEP, by means of its related agencies, is a part of the ANUIES structure and maintains a good relationship with this organization. Quite frequently, those agreements reached by ANUIES members are considered compulsory once they are endorsed by the SEP, the universities and higher education institutions.

The evaluation of higher education in Mexico has been one of the major concerns of ANUIES and the SEP. As a result of this the National Education Evaluation Commission (Comisión Nacional de Evaluación de la Educación, or CONAEVA) was created in 1989. Evaluation at this level involves three parallel activities: institutional self-evaluation, evaluation between similar institutions where teachers evaluate another institution with curricula similar to their own, and the external evaluation of the system using various methods.

Both public and private higher education institutions set the regulation standards for the programs they offer, as their autonomous status and their bylaws grant them such a right. Two factors are relevant regarding the definition of standards regulating the drafting, implementation and evaluation of the curricula. The university central structure, usually represented by general boards and their offices, as well as academic and administrative officials, is the level at which the minimum and general features of the curricula, faculty and student policies, the analysis and approval of the curricula, study programs and other proposed projects, as well as the sources and use of material and economic resources are defined. The second factor is the schools and faculties themselves. With respect to the above mentioned minimum criteria, the Technical School Boards define those issues that are of particular interest depending on the disciplinary fields and the programs involved in terms of the curriculum, students, faculty and resources. The definitions (regulations) include the following significant issues:

1. **Curricula**
   - Justification of the program of study (market studies and others showing the social need for professionals in any given field)
   - Frame of reference reflecting the values and basic concepts of the study area in question (basis for deriving outlines, a theoretical approach, methods and other issues related to curriculum organization and the learning process)
   - Time frame (number of years or semesters and number of academic credits)
   - Number of classroom, laboratory or clinical field hours per week
   - Number of weeks per semester or academic period
   - Curriculum schedule (number of subjects, modules or other)
   - Description of program content
   - Teaching and learning evaluation methods
   - Curriculum validity
2. **The Faculty**
   - Admission performance and evaluation requirements and procedures
   - Type of professionals needed depending on the experience area and teaching and research skills
   - Functions and responsibilities
   - Program to train and update faculty
3. **Students**
   - Education requirements
   - School transcripts
   - Vocational requirements
   - Selection procedures (grade average, examinations, psychometric tests, etc.)
   - Procedures and criteria for academic progress and completion of studies
4. **Resources**
   - Physical facilities (classrooms, laboratories, offices, auditoriums, recreational areas, bathrooms)
   - Library and research facilities
   - Teaching technology (audiovisual, computers, communications)

- Budget
- Clinical field (community centers, second and third level hospitals, and other hospitals according to the curriculum content and programs conducted)
- Institutional development program
- Relating with the environment (business, hospitals, community or citizens' groups)
- Institutional research programs or guidelines
- Curriculum evaluation program or system

Higher education institutions often have a committee or group that is in charge of monitoring the above mentioned issues. When a private school is incorporated to a university, a group or committee of nursing teachers from the university supervise compliance with standards (or the minimums established) regarding the curriculum, faculty, students and resources. This commission submits a report to the relevant academic and administrative authorities who, in turn, use that report as a basis for renewing or not renewing the incorporation of the school in question. This procedure takes place every one to two years.

The professional degrees issued by the higher education institutes and the technical schools incorporated to the SEP and universities are Bachelor in Nursing (with some variations, such as Bachelor in Nursing and Obstetrics), Nurse, or Nursing Technician. In the case of technical schools incorporated to the SEP, a diploma is issued. The curricula for the degree in Nursing and Nursing Technician are not clearly differentiated, since the admission requirement in both cases is the junior high school certificate and the course duration is three years (in some cases, two years of full time study). Some schools offer high school programs combined with a nursing program with a duration of three or four years. However, the degree granted makes no reference to these studies.

The professional degree is the legal document required by the DGP-SEP to grant the license, Cédula Profesional, which is an authorization to practice the profession, but not equivalent to certification. The school curricula must first be registered with the DGP for a license to be granted. Both the graduate and the school must also comply with a series of requirements and administrative procedures before a license is granted (a passing grade in all subjects included in the curriculum, community service compliance, a passing grade in the professional examination[4] or the graduation method). Once graduates receive their license, they are not required to renew or update it.

Role of the Beginning Nurse

In accordance with the graduation profiles of the technical and baccalaureate programs, graduates are prepared as generalists who are able to use scientific knowledge. They can perform direct care as well as manage and coordinate nursing services. Graduates from the technical and baccalaureate programs are hired to fill general nurse positions at health care institutions at the first, second and third levels.[5]

The hiring institutions primarily take into account the degree earned by the person seeking employment; theoretically, experience is not taken into account, but in practice it is considered. An exception to this is the hiring of personnel for the intensive care and operating room areas. Previous experience in these areas is necessary, and personnel generally are required to have a "specialty" (a post-technical course).

In their first job assignments, technical nurses must be supervised by experienced nurses for a period of two to three months. If recently graduated technical nurses are hired by government institutions or low-income health care facilities, they may be responsible for a service or a hospital unit. In such cases, physicians support the professional development of technical nurses.

Graduates of baccalaureate programs may obtain jobs with highly specialized third level hospitals. They also are supervised by an experienced nurse, but that supervision might be lifted after a six-month trial period.

Usually, graduates from both the technical and baccalaureate programs perform direct services, that is, they center their activities on patient care and follow instructions from physicians. Baccalaureate graduates are more likely to be quickly "promoted" to administrative positions in some health care institutions.

Admission Requirements

At present, two education levels in nursing are acknowledged: technical and baccalaureate. Graduates from both programs are accepted in the job market as professional staff, even though their education levels are different. An admission requirement for the technical program is the junior high school certificate, which is awarded for passing six years of elementary school plus three years of junior high school. This certificate, plus the senior high school certificate (three years of senior high school for a total of 12 years), is an admission requirement for the baccalaureate program.

Applicants for nursing programs must first pass the general admission examination offered by the institution to which they are applying. Currently, a voluntary national

examination is administered to candidates for high school and higher education. A pilot national examination for high school (EXANI1) was administered in 1993, and one for higher education (EXANI2) in 1994. These examinations were prepared by the National Center for Higher Education Evaluation (Centro Nacional de Evaluación de Educación Superior; CENEVAL, 1995).

The four-year baccalaureate programs are offered at universities and higher education institutes, while the three-year technical programs are offered both at universities or incorporated schools and higher education institutions, in most cases at private or public schools certified by the SEP.

Main Elements and Content Areas of Education Standards

The proposal for *Basic Nursing Education Standards* was primarily focused on characteristics of the educational institutions and the mechanisms for coordination with health care institutions. Due to the time elapsed since they were first drafted (1985), the content is out of date; however, the elements included are worth consideration. Considering the issues regulated and monitored by universities at their own schools and at certified schools, it can be assumed that general standards for nursing education exist in such areas as curriculum, students, faculty and resources.

Impact of Standards

While no information is available on the evaluation of the standards' impact, the implementation of the standards by health care institutions (which have adopted them to authorize the clinical practice of their nursing students) has resulted in better and more timely planning and coordination between nursing service and schools and a greater focus on the education of students, on nursing service personnel and on attention to patients.

Funding Sources for Nursing Education

Nursing schools that are part of a university or a government institution receive financial resources from the state and federal governments, some self-financing, and a small amount of funding in the form of tuition fees paid by students. In the case of private schools, students are the main source of financing. However, both private and public schools have very limited budgets that are insufficient for the quality levels demanded of them. Two entities might possibly provide some additional financing for nursing schools (particularly, for special projects). These are: ANUIES and the National Science and Technology Board (Comité Nacional de Ciencia y Tecnología, or CONACYT). Some schools have received additional financing and/or assistance from social and development entities such as the National Solidarity Program (Programa Nacional de Solidaridad, or PRONASOL) and from international organizations, such as the Pan-American Health Organization (PAHO/WHO) and the World Bank, as well as from private institutions, such as the W.K. Kellogg Foundation. Some other sources of financing might be obtained from embassies in Mexico by means of special agreements.

Ten-Year Projections for Nursing Education Standards

Trends Influencing the Standards

The globalization of markets, and in particular the North American Free Trade Agreement (NAFTA) between Canada, Mexico and the United States involving the cross-border exchange of services; the economic and social policies implemented by the Mexican government in response to the crises affecting this country; the everyday experience of professional nurses (with a trend toward independent nursing practice)[6]; and the necessity to raise the academic level of higher education emphasize some global trends that might influence the standardization of nursing education. The most significant influences include reforms in the health care area, social programs and poverty levels of the population, higher education policies and transition epidemiological profiles.

Reforms in the Health Care Sector

Structural changes in Mexico's Health Sector began in 1982. A direct relationship between health standards and development is presently acknowledged. The Health Care Reform Program, 1995-2000 (1995, p. 19), states that "...the most evident contribution of the health care activities to the development of society is seen in preserving the population's health standards..." This is why health care policies are part of the development programs with "...the necessary harmony... between both and the need to work with other sectors..." based on programs for:

- Universal coverage, equality and solidarity;
- Efficiency, efficacy and quality patient care; and
- Decentralized management.

Although some progress has been made, there are still high mortality rates and transition epidemiological patterns in the various states of the country, where diseases characterizing underdevelopment coexist with modern diseases. The current health care system emphasizes treatment of

the sick at second and third level hospitals offering centralized services, strategies, and budgets that have an impact on performance and contribute to cost increases.

In 1994, seven million people had no access to health care services and another three million had limited access and poor quality service. These people live mostly in underdeveloped rural areas and unserviced urban areas, and their disadvantageous social and economic conditions make them prone to infectious and communicable diseases, addictions and violence. Therefore, health care reform is aimed at:

- Expanding the scope of health services to reach populations with limited or no services.
- Reorganizing expenditures in health care to guarantee basic health services for the entire population.
- Decentralizing health services to the states.
- Introducing competitive programs at health care institutions to raise quality of services.
- Providing the best preparation for health care personnel.
- Expanding the scope of social security services by modifying the contribution plan currently in force to make it easy for freelance (informal) workers to have access to these services.
- Consolidating the Health Secretariat as the agency in charge of regulating the National Health System and emphasizing coordinated activity within and between government agencies (1995-2000 Health Sector Reform Program, p. 26).

A consequence of the changes in the health care system will be a dramatic modification of the job market. The nursing job market at hospitals is presently dominated by government-owned health care institutions that will change the type, quality and cost of the services they provide in the years to come. An emphasis will be placed on first-level prevention health problems. The modified Open Service Model[7] will be used to expand health care coverage to all the population.

Along these lines, education standards must take into consideration the curricula approach as they might respond to the demand for human resources by institutions instead of the needs of the population. Similarly, the role of nurses will undergo dramatic changes, some of which may not be always beneficial. Therefore, we must be aware of not isolating nurses' education from the real world of service and from the opening of new professional fields, such as nursing independent practice (either individually or in groups), and nursing services at home, schools, industries and communities. The lack of leadership, research skills and use of technology in the nursing profession, as well as the lack of differentiation in nursing education programs and professional nursing practice, must be overcome to prevent nursing from lagging behind other professions.

Poverty and Social Spending

Poverty is a pervasive problem in Mexico (1995 National Development Program). Roughly 60 percent of the working population make two minimum wages a month (approximately 170.00 U.S. dollars) and sometimes less than that (INEGI, 1995). This situation has an impact on the health status of individuals, particularly on children and the elderly. The social assistance programs favoring the low income population with subsidies for food, housing, health and education are receiving increasingly less funds. According to figures calculated by Zepeda Miramontes (1994), social development expenses in 1982 amounted to 9.1 percent of Mexico's GDP, but this figure decreased to 6.0 percent by 1988, and now stands at 8.6 percent. These facts jeopardize the possibility of having health care services with universal coverage and improved quality, since the social programs include funds for health programs dedicated to the most needy population.

Higher Education Policies

Globalization will have an impact on Mexico's education system and particularly on nursing education. Nursing faculty are being pushed into a competitive system of academic degrees and scientific production to which they are not accustomed and which places them at a disadvantage. Likewise, students will also feel the impact on education as more emphasis will be placed on preparation processes rather than the process of information acquisition.

Another issue to be considered is the change in financing policies for higher education. The possibility exists that academic excellence criteria will be the basis for the allotment of budgets at universities and higher education public institutions. This may have a negative impact on the status of nursing programs at universities, as the faculty might be in a disadvantageous position in terms of its training and research skills. Admission requirements of students and performance standards of graduates also are likely to be affected. A possible outcome of this policy change might be the gradual disappearance of the baccalaureate and of graduate studies in nursing.

In this context, the national admission examination for university programs, scheduled to be administered on a regular basis in the future, is another factor that will influence nursing program standards. The impact will be seen on: a) a redefinition of the curricula, as the knowl-

edge levels of students will be more precisely ascertained; b) the design of strategies aimed at raising the demand for nursing studies, as the demand is currently low because there is no clear difference in terms of academic levels and salaries in the job market; and c) the quest for economic and material resources that will permit the survival of nursing schools, as funding might be lost in view of the lack of demand.

Finally, "open" or "career-ladder" curricula will have to be promoted so that practicing nurses may return to the formal nursing education system and that, in turn, will require a change in the stringent standards for the progress and graduation of students. Also, the expansion of the settings where nursing services are offered will require a change in the competencies expected of graduates and in the clinical settings (institutions and others) used to provide learning opportunities for nursing students. Similarly, the rules and standards to be used for the validation of studies will have to be more universal than at present.

Emerging Regulatory Issues

Professional Colleges and Nursing Associations

One way to work at the national and state levels is by creating federations. This means that the various professional schools join forces to be better able to reach common goals. A case in point is the state of Nuevo Leon, where the Federation of Professional Schools (Federación de Facultades Profesionales) has signed an agreement with the State Congress aimed at strengthening the law-making efforts of Congress members through the academic and technical contributions from the Schools.

Another example is the proposal for a "Nursing Training and Professional Practice Regulation" advanced by the CNE (as described in Part III). Should this proposal be approved by the Chambers of Representatives and Senators, it will become the legal foundation from which the nursing profession can derive standards regulating nursing practice and education.

The Committee for the National Nursing Accreditation and Certification System (Sistema Nacional para la Acreditación y la Certificación de Enfermería, or SNACE) is a work group created by the CNE in January 1994 as a response to the task entrusted to it in November 1993 by the Undersecretariat for Higher Education and Scientific Research (Subsecretario de Educación Superior e Investigación Cientifica). The purpose of this committee is to develop a nationwide project that complies with the commitments for the profession derived from the NAFTA agreement regarding the setting of standards and criteria acceptable to all parties (Canada, Mexico and the United States) for the granting of licenses and certification to nurses and university students. The committee also is to make recommendations for recognition among the three countries.

The SNACE Committee has taken part in the Trilateral Initiative for North American Nursing along with representatives from its counterparts in Canada and the United States. This Committee drafted a paper on the education and professional practice of nursing in Mexico and the applicable standards. This paper was presented at the Trilateral Initiative Conference on the "Globalization of Higher Education: The Case of North America" held in Cancún, Mexico in May 1994.

SNACE is composed of representatives from the CNE (involving the 31 state Colleges and Associations), the National Association of Bachelors in Nursing (Asociación Mexicana de Licenciados en Enfermería, or AMLE), FENAFEE, the Nursing and Obstetrics School of the National Polytechnical Institute (Facultad de Enfermería y Obstetricia del Instituto Politécnico Nacional, or ENEO/IPN), the Nursing and Obstetrics School of the National Autonomous University of Mexico (Facultad de Enfermería y Obstetricia de la Universidad Nacional Autónoma de México, or ESEO/UNAM), the SSA, the IMSS, the ISSSTE, the Nursing Section of the Mexican Association of Private Hospitals (Sección de Enfermería de la Asociación Mexicano de Hospitales Privados) and other representatives from the National Health Care System (SNACE/CNE Project, January 1994).

FENAFEE has assessed most of the affiliated schools, using the prospective analysis methodology and examining elements that are general functions of universities (teaching, research, services expansion, cultural dissemination and administrative support). Also, FENAFEE plans to draft the *Standards for Accreditation of Institutions and Curricula* for both the technical and baccalaureate levels. The most concrete proposal that was derived from two meetings in May and June 1995 involves the restructuring, enforcement and evaluation of nursing education standards in Mexico. FENAFEE is composed of some 66 nursing schools and its structure allows it to work in 29 states of the Mexican Republic through nine regional associations.

Interinstitutional Commission for the Preparation of Health Resources (Comisión Interinstitucional para la Formación de los Recursos Humanos para la Salud, or CIFRHS)

While this Commission has continued to work during the past eight years, very little activity for nursing was registered during the 1989-1994 administration. The activity

was resumed in 1995. The General Health Education Directorate for the SSA has just created the "Nursing Work Group" (through the Planning Committee) for the purpose of conducting studies and drafting proposals for nursing education, the job market, and the human resources information system.

National Interinstitutional Commission for Nursing (Comisión Nacional Interinstitucional de Enfermería)

The strategic plan for the National Nursing System (DGRS, 1994) of the National Interinstitutional Commission for Nursing provides for support to projects aimed at establishing an accreditation system for educational institutions and their study programs and for certifying nursing professionals. The health and education services in some states of the Mexican Republic (e.g., Nuevo Leon) have promoted the creation of similar commissions to continue drafting standards for nursing schools in each state of the country and for professional practice.

Mexican Committee for the International Practice of Nursing (Comité Mexicano para la Práctica de Enfermería en el Extranjero, or COMPIE)

This group was created in September 1994 by the General Professions Directorate (Dirección General de Profesionistas, or DGP) for the SEP. COMPIE's purpose is to draft recommendations for the mutual recognition of licenses and certificates at baccalaureate levels as provided for by the section on "Granting of Licenses and Certificates" of NAFTA. The Committee is made up of representatives from the National Association of Bachelors in Nursing (Asociación Nacional de Licenciados en Enfermería), the CNE, FENAFEE, the ESEO/IPN and the ENEO/UNAM. COMPIE's three work groups focus on curricula, professional practice, and code of ethics.

Professional Quality Examination

A mechanism aimed at determining the knowledge level of baccalaureate graduates, including nursing graduates, is the Professional Quality Examination. This examination, designed to assess the knowledge level of students about to graduate with a baccalaureate degree, is based on the outcomes of the program of study. The organization promoting this project is the National Higher Education Evaluation Center (Centro National de Evaluación de la Educación Superior), which has formed commissions organized by profession in an effort to draft the relevant examinations (CENEVAL, 1995). In the case of nursing, the commission includes representatives from FENAFEE and ANLE, and nurses representing various health care institutions. As of August 1995, candidates for graduation may choose to take this examination, which will allow them to show evidence of the quality of their education to the public, the hiring institutions and their schools.

Anticipated Changes to the Elements and Content of Education Standards

The basic standards must take into account the background information detailed earlier in this chapter. The analysis of the trends in education, health care and the profession will allow us to define the most important elements and content to raise the quality of standards in nursing education.

The education standards will likely focus on curricula, students, faculty and available resources. These elements should include the following content:

1. The social importance of the profession. In this regard, nursing education should revolve around society and its health and well-being needs, and not only around institutional health services, as has been the case so far. Three elements must be considered in this regard: a) the level of involvement and decision-making power to be enjoyed by health service users, whether individuals, groups or communities; b) a total understanding of the social environment, since health may be impacted by many factors; and c) the need for various professionals and disciplines to approach the problems involved in professional practice.
2. The need to stress the central role of nursing in the curricula and in the services and locations where professionals are prepared.
3. The urgent need to change dramatically the nursing education process from "informational" to "formational", including the use of state-of-the-art technology.
4. The demand for services and the responsibility of education authorities to train and update active nursing practitioners working in Mexico.
5. The expansion of roles, locations and circumstances where future graduates will work. This will go beyond the limited scope of action of "institutional practice".

Nursing education standards will have to guarantee that graduates will perform successfully in a complex and changing environment, both in their professional practice and in any graduate studies they pursue.

Future Challenges in Standards Setting

Implementation of Standards in Mexico

This process will involve the continuation of the standards drafting process. Once standards are defined, a pilot test of the standards will be conducted, followed by their implementation and evaluation. As with any other working plan, adjustments to the process will be made based on regular evaluations. The process for the drafting of education standards is a complex task, as it covers national and international areas as well as academic and administrative areas involving individuals, nursing groups and government agencies. Thus it will be necessary to find the most efficient mechanisms to establish and maintain both formal and informal communication among the participants and with the nursing profession. Leadership and decision-making will be the cornerstones of this process.

The experience of the CNE in the drafting of the *Nursing Training and Professional Practice Regulation* (1989-1994) described in this chapter, demonstrates obstacles encountered and the strategies used to achieve sustained activity, consensus and results. The analysis of successes and failures in this process will be valuable for improving effectiveness.

Potential for Eliminating Differences Within Mexico

In Mexico, differences regarding what aspects of nursing to regulate and the desired quality level for nursing education may stem basically from the inequality of human, technical and material resources available in the various states or regions. Regionalization might be an appropriate strategy for the elimination of such differences. Regionalization would be a gradual process aimed at guaranteeing a minimum quality of nursing graduates and some degree of assurance for nursing service users.

The following recommendations are made for Mexico:

- Colleges and Associations must recover their role as self-regulating entities with the support of the General Law on Professions.
- Nursing education standards must be drafted based on the evaluation of results model in order to meet three of the objectives identified: a) the standardization of nursing education, b) the raising of the academic levels of nursing faculty to graduate levels, and c) the same admission requirement (12 years of previous education) for both technical and baccalaureate academic levels.
- Hiring institutions must comply with the provisions of the General Law on Professions so that nursing services both inside and outside hospitals are delivered only by qualified nurses.
- Accessible mechanisms must be created at the universities and in coordination with health institutions to allow nurses to raise their academic levels.
- Graduate programs (specialties and above all, master's degrees) must be strengthened.

Potential for Eliminating Differences Among Canada, Mexico and the United States

The following recommendations are made within the framework of the trilateral agreement:

- Conduct a detailed comparative analysis of the standards of nursing education to clearly define the scope of action of the beginning nurse and that of students of various programs and academic levels.
- Continue with the collaboration process among schools, associations and nursing councils in Canada, Mexico and the United States (identified to take on this commitment) that have made an assessment of the education standards, identified similarities and differences among the countries and described some strategies to eliminate those differences. This was the first stage of the work program. This collaboration will facilitate self-regulation in accreditation and the improvement of nursing schools and education programs, particularly in Mexico.
- Acknowledge and respect the autonomy of each country and identify the future trends of the standards to be agreed upon for education programs and their equivalence.

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Footnotes

1 In accordance with the provisions of their by-laws and general regulations on technical and professional studies and the recognition and studies validation regulations for incorporation and studies validation.

2 In accordance with the General Law on Public Education and with the Law for the Coordination of Higher Education and the Internal Regulations of the Public Education Secretariat.

3a. A credit is a value or score unit for a subject that is estimated as follows:

- In activities requiring study or additional work from students, such as in theoretical classes and seminars, one hour of class per week, per semester is equivalent to two credits.
- In activities not requiring study or additional work from students, such as exercises, laboratories and workshops, one hour per week per semester is equivalent to one credit.
- The value in credits of clinical activities and practices for the learning of music, fine arts, and training for the job market will be computed as a whole according to their importance to the curriculum and the criteria of the relevant academic entities.

b. Credits will always be stated in whole numbers and shall correspond to 15 weeks of effective classes; additionally, this will be the minimum duration of a school semester. Credits for courses with a duration of less than one semester will be computed as a proportion of their duration and number of class hours per week.

4 Professional Examination: Evaluation conducted by an official educational institution on an individual who has successfully completed a given school curriculum.

5 The first level emphasizes the promotion of health and the prevention of diseases. The second level includes the four levels of medicine (internal medicine, general surgery, pediatrics and gynecology-obstetrics, though some hospitals include services for mental health). The third level offers a high degree of specialization accompanied by sophisticated technology (Psychiatric services belong to the third level of hospital services).

6 This refers to independent nursing practice either on an individual basis or through nursing services bureaus.

7 This model is aimed at providing health services for those people with no access to social security services either because they have no permanent job, are peasants or work on their own on an irregular basis.

Standards of Nursing Education in the United States

Shirley Fondiller EdD, RN, FAAN
National League for Nursing

Joyce Murray EdD, RN, FAAN
National League for Nursing

Executive Summary

The development and evolution of educational standards for entry into nursing practice in the United States spans more than 100 years. Leaders from the past have handed down a rich legacy of activities devoted to advancing nursing's educational system and improving practice. An overview of the origin and evolution of nursing education standards is presented in this chapter.

The current status of nursing education standards is explored from different perspectives. Standards used by regulatory authorities, governmental and non-governmental, are included. The main elements of these standards, the role of the beginning nurse, levels of education for entry into practice, and the impact of education standards provide the framework for this exploration.

The final part of the chapter presents a ten year projection for standards of nursing education in the United States. These projections are based upon health care trends, emerging regulatory issues, anticipated changes to the standards, and the process for changing standards. Developing standards of nursing education for the future is envisioned as a dynamic, complex, and challenging process.

Historical Overview of the Origin and Evolution of Nursing Education Standards

For decades, the vast majority of nursing schools in the United States were operated and owned by hospitals for the sole purpose of providing nursing care for patients. During the early period of nursing in the United States, subordination of the needs of the schools and students to those of nursing services resulted in student exploitation, sketchy curriculums, unqualified and inexperienced teachers, unsuitable classrooms, and sparse library and other resources. These conditions persisted as nursing schools proliferated.

It soon became apparent that the grave problems facing nursing could be solved only through the organized, collective action of nurses. This recognition led to the founding of the American Society of Superintendents of Training Schools for Nurses in 1893. From its inception, the Society, renamed the National League of Nursing Education in 1912, made its principal goal the establishment and maintenance of universal standards of training. Its leaders pioneered the formation of the Nurses Associated Alumnae of the United States and Canada in 1896. In 1911, this organization became the American Nurses Association (ANA).

The purpose of the Nurses Associated Alumnae was to strengthen the union of state nursing groups, elevate nursing education and practice, and promote ethical stan-

dards in the profession. Nursing's major concerns related to developing greater uniformity in the curricula of schools of nursing, and obtaining legal recognition for nurses.

In 1920, the National League of Nursing Education (NLNE) established a set of minimum standards and began accrediting advanced programs in public health nursing. The schools with a baccalaureate program had added public health nursing to their curricula. Another national organization, the Association of Schools of Collegiate Nursing (ASCN), formed in 1933, aimed to define objectives, develop standards and policies, and encourage experimentation in college and university nursing programs. Several studies on nursing education standards were undertaken by the NLNE and the National Organization for Public Health Nursing (NOPHN), which had been established in 1914.

Over the years, NLNE attempted to define educational standards, and in 1937, issued *A Curriculum Guide for Schools of Nursing*, which critically examined the basic pattern of the curriculum and the materials and methods of construction. It also explored a philosophy of nursing education, goals to be targeted, appropriate services for nurses, and the desired basic preparation. It was not until the late 1940's, however, that efforts intensified to unify nursing's educational system. In 1947, the NLNE enunciated its position on the organization, control, and administration of nursing education. In a statement of principles, it advocated university preparation for professional nursing.

The NLNE document was reinforced the following year by the publication of a significant report entitled *Nursing for the Future*. Known as the Brown Report (after the study director, Esther Lucile Brown), its recommendations caused controversy both within and outside the nursing profession. The Brown Report pinpointed the continued inadequacies of nursing education identified in earlier studies and strongly recommended that basic nursing education take place in schools of nursing in universities and colleges. These recommendations posed a threat to hospital diploma schools, which produced the largest number of nurses at the time, and particularly to administrators, physicians and graduates of the diploma programs. This reaction stymied efforts to relocate nursing preparation within the higher education system, and several years would pass before organized nursing resumed its efforts in that direction.

By the late 1940's, the National Nursing Accrediting Service was established to foster closer relationships among the various nursing groups. When the profession gave birth to a new structure in 1952, consolidating several organizations into the ANA and the new National League for Nursing (NLN), the latter inherited the accreditation interests of the NLNE, NOPHN, and ASCN. Criteria that had been agreed upon by all of the organizations were brought together and published under the heading, *Manual of Accrediting Educational Programs in Nursing* (Kelly, 1985). Even though accreditation is a voluntary activity, the NLN was officially recognized in 1952 by the Department of Education as the accrediting body for associate degree, baccalaureate and higher degree, diploma, and practical nursing programs.

Major studies in the 1950's (*Nursing Schools at the Mid-Century*, 1950; *Patterns of Patient Care*, 1955; and *Twenty Thousand Nurses Tell Their Story*, 1958) continued to focus on the status of nursing education programs and the functions of nursing. In 1959, Mildred Montag wrote Part I of a five-year Cooperative Research Project in Junior and Community College Education for Nursing Education. Seven two-year programs leading to an associate degree in nursing were established. The associate degree nurse was intended to be a "bedside nurse" who was not burdened with administrative responsibilities. The functions of the associate degree nurse included assisting in planning of nursing care, giving general nursing care with supervision, and evaluating nursing care (Kelly, 1985). Initially, the associate degree was considered a terminal degree and not the first step to the baccalaureate degree. Today RN to BSN or RN to MSN programs provide opportunities for the progression of associate degree nurses to the baccalaureate or master's level.

NLN's program for specialized accreditation, housed within the Division of Nursing Education, became a significant force in raising educational standards of all types of basic nursing programs as well as those leading to a master's degree in nursing. Through its departments of baccalaureate and higher degree programs, and diploma and associate degree programs (separated into two departments in 1965), educational standards and accreditation activities were developed.

It was a particularly high point for the profession in December 1964 when comprehensive federal legislation authorizing financial assistance for nursing education recognized the accreditation standards of the NLN. Under the Nurse Training Act, the assurance by schools of nursing that they could meet these standards within a reasonable time became a condition of eligibility for financial assistance.

In late 1965, the ANA released its first position paper on nursing education, recommending baccalaureate preparation for professional nursing practice and associate degree preparation for technical nursing practice. Throughout the 1970's and 1980's, studies continued to focus on entry into practice, credentialing and its relation-

ship to licensure, registration, certification, educational degrees, accreditation, accountability, and competence. Credentialing centers certified nurses in various specialty areas and the NLN continued as the official accrediting body for all entry levels of nursing education, i.e., associate degree, baccalaureate and higher degree, diploma, and practical nursing programs.

Purpose of Standards

Educational standards are inherent in licensure eligibility, accreditation, certification and academic degrees. State regulatory bodies set standards for nursing education programs to assure that graduates are safe practitioners who are eligible to take the National Council Licensure Examination (NCLEX), and thereby protect the public.

NLN educational councils are dedicated to developing and improving the standards for quality nursing education, service, and health care delivery in the United States. Each educational council is accountable for the standards of the academic degrees and/or type of program designated in its title.

Certification standards assure that the individual has met certain standards in a clinical or functional area beyond those of the non-certified nurse. The ultimate goal of all educational standards is to assure quality nursing education programs that prepare safe and competent practitioners.

Current Status of Nursing Education Standards

Regulatory Authority

In the United States, regulation in the nursing profession is implemented through four credentialing mechanisms: licensure, accreditation, certification, and academic degrees.

Licensure: Governmental Regulation

For the profession of nursing, governmental regulation operates through legislation that protects the public by setting standards for entry into the profession and for removing unqualified practitioners. These laws, or Nurse Practice Acts, define the practice of nursing and describe its scope within the respective states.

Each jurisdiction/state has a Board of Nursing, which holds the power to issue, renew, revoke, and suspend licenses for professional and practical nurses, to grant endorsement for nurses licensed in other states, and to set continuing education requirements for relicensure. Boards of Nursing develop rules and regulations to implement in broad terms their Nurse Practice Acts.

The Nurse Practice Act of each state or jurisdiction provides the authority for each Board of Nursing to regulate nursing education. Rules and regulations from each state determine the mechanics by which this is accomplished. Because each Board of Nursing must respond to the specific needs of its state and jurisdictions, educational standards and regulations vary throughout the country. Generally, rules include standards related to organization and administration, curriculum, faculty, resources, evaluation, and performance of graduates.

Boards of Nursing oversee the development of all entry level nursing programs, including associate degree, baccalaureate degree, diploma, generic master's, and generic nurse doctorates. Standards and regulations for each level may exist. Approval of a program is a public action and signifies compliance with the law and rules of the state or jurisdiction.

Overseeing the licensing examination is the National Council of State Boards of Nursing (NCSBN), a free-standing organization formed in 1978 and comprised of member boards. NCSBN works in conjunction with the Educational Testing Service (ETS), a privately operated company. The purpose of the licensure examination, called NCLEX (National Council Licensure Examination), is to maintain quality control, guaranteeing a minimum degree of competence necessary to ensure the health, safety, and welfare of the public.

Historically, the NLN and ANA have worked closely with state Boards of Nursing. As far back as 1912, the concept of the present NCSBN had its roots during the ANA convention when delegates established a committee to improve methods and procedures of member boards, and to assist basic nursing programs preparing nurses for licensure.

The 1937 NLNE *Curriculum Guide* had implications for state boards in that it focused attention on the objective evaluation of the nursing student. With the extended scope of nursing practice beginning in the late 1960's, significant changes occurred in legal regulation of the practice of nursing. The impetus was the evolving role of the nurse practitioner, a new type of health professional whose advanced practice work in primary care differed from the traditional model. Thus, changes in Nurse Practice Acts took place along with health insurance laws and the promulgation of rules and regulations to support the advanced practice of nursing.

Through its various committees and interest groups, the National Council has generated a number of important position papers and statements since the 1980's. It has dealt with issues relating to nursing education and practice, such as entry into the profession, law and ethics, and the impaired nurse. Some of its other concerns have included continued competence, application of computer

technology for licensing examinations, and regulation of advanced practice.

The power of State Boards of Nursing cannot be underestimated in light of their intervention into areas once considered the exclusive province of the voluntary professional association. At NCSBN's 1993 Delegate Assembly, participants adopted a *Position Paper on the Regulation of Advanced Nursing Practice and Model Legislative Languages and Administrative Rules.* Subsequently, Boards of Nursing have been reviewing changes in their laws and rules in relation to the regulation of certified nurse-midwives, certified nurse anesthetists, clinical nurse specialists, and nurse practitioners.

Accreditation: Nongovernmental Regulation

Accreditation in the nursing profession evolved later than the licensure movement. The need to regulate nursing practice through educational standards, in addition to maintaining a tradition of nongovernmental interference, led to the unique system in the United States known as voluntary accreditation.

Accreditation is defined as the process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards. It is designed to reflect excellence in nursing programs, to attract qualified students, and to encourage external funding.

The standards established by the four educational councils of the National League for Nursing have represented that organization's authority as the voluntary, nongovernmental regulating body for the nursing profession (NLN, 1991a; 1992a; 1992b; 1994c). As a specialized accrediting body, the NLN provides for the maintenance and enhancement of educational quality and contributes to the improvement of nursing practice.

NLN accreditation is peer evaluation in which program evaluators verify, clarify, and evaluate the data presented in the self- study report prepared by each nursing program applying for accreditation. The program evaluators, selected and trained by the NLN, are faculty and/or administrators of like programs. More recently, greater flexibility has occurred in ways to meet accreditation standards, so that programs of varying educational approaches are being accredited. Quality remains the chief indicator. By 1994 over three-fourths of all basic registered nurse programs were NLN-accredited.

Certification

In the United States, certification demonstrates a nurse's specialized knowledge and skills. It is a voluntary, peer-review process that promotes competency, visibility, marketability, and quality among nurses. It also reflects professional growth.

Nurses earn their certification through examination and other criteria stipulated by the certification board in their respective clinical area. Certified nurses with a baccalaureate or lesser educational credential are considered generalists working in a specialty area. Only RN's with advanced formal preparation, that is, with a minimum of a master's degree in nursing, can be certified as specialists. Although both groups carry the designation of certified nurse, there is a marked difference in the scope of their responsibilities.

While almost 200,000 nurses are certified, the standards vary among the certification boards that represent the numerous specialty organizations. The American Board of Nursing Specialties was established in 1991 to promote consistency and encourage uniformity in standards and requirements for achieving certification.

Certification is based on two principles: (1) It is voluntary and (2) the organization or agency that certifies is nongovernmental and consists of experts in that particular field. As a professional regulatory mechanism, nursing certification aims to show the U.S. healthcare consumer that the individual has met certain standards in a clinical or functional area beyond those of the non-certified nurse.

During the early 1970's, the ANA initiated a certification program. In 1989, the American Nurses Credentialing Center (ANCC) was established as a separate entity through which the ANA would serve its own credentialing programs. The ANCC has recommended that RN's wishing to acquire generalist certification must have a baccalaureate in nursing by 1998.

Level of Education for Entry to Nursing: Academic Degrees

During the 1980's, the NLN and the ANA reached consensus on baccalaureate education for entry into professional nursing. At present, NLN's position is to support multiple entry points into nursing and to enhance multiple models for education. Also supporting university preparation for nursing is the American Association of Colleges of Nursing (AACN), a national organization established in 1963 to advance the quality of baccalaureate and graduate education, promote nursing research, and develop academic leaders.

Following the ANA's lead, most state nurses associations now support baccalaureate preparation for professional nursing practice and associate degree preparation for technical nursing practice. Among the member boards of the NCSBN, several have taken formal positions on

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entry standards. In addition, a number of national nursing specialty organizations have made official pronouncements about education for professional nursing.

The system of nursing education in the United States continues to be complex, encompassing several entry levels. In 1994, the NLN reported that 57 percent of the 1,484 entry to licensure registered nurse programs were associate degree, 34 percent baccalaureate, and nine percent diploma (NLN, 1994d).

The NLN educational councils have developed statements defining the role and characteristics of the three types of basic programs as well as practical nursing programs. In 1986, AACN delineated the essentials of professional nursing education that provide a standard by which faculty could measure the content of the curriculum and the performance of the graduates (AACN, 1986)

At present, enrollments in nursing schools are on an upswing, reaching an all-time high of 270,228 in 1993. The following describes the prelicensure RN nursing education programs in the United States.

The Baccalaureate Nursing Program

Most programs leading to a bachelor of science degree in nursing (BSN) are four years in length (some longer work-study programs also exist), and are located in colleges or universities that offer the first professional degree in nursing. The BSN program has grown dramatically in the past three decades, with more than 500 baccalaureate programs offered today, compared to fewer than 200 in the 1960's.

Baccalaureate nursing education aims to help students to develop the ability to think critically and apply their knowledge skillfully in the care of individuals, families, groups, and communities. It provides the groundwork for obtaining a college degree in nursing and for taking the licensure examination to become a registered nurse. Furthermore, it is the foundation for formal graduate study in nursing.

BSN programs are comparable to undergraduate education for other disciplines in that students are required to meet the same general admission standards of the university. The majority of programs offer liberal arts and science courses during the first two years, followed by the nursing major in the upper division. Pre-nursing courses generally include biology, anatomy, physics, chemistry, physiology, English composition, a foreign language, sociology, nutrition, ethics, and business management.

Nursing classes focus on the promotion, maintenance and restoration of the health of individuals, families, groups, and communities. Programs encompass theory and clinical learning experiences. Courses include basic and advanced concepts of nursing, adult health, pediatrics, mental health nursing, women's health, pharmacology, beginning research methods, social and professional issues and trends, nursing leadership, and other topics. Most BSN programs require at least 120 semester credits, with about half concentrated in the nursing major.

Baccalaureate nursing education prepares the new graduate to work in the widest range of health care settings, including staff positions in hospitals, public health and visiting nurse agencies, and other organized nursing services. Consistent with its criteria for evaluating baccalaureate and higher degree programs, the NLN issued statements that characterize the graduate of the baccalaureate nursing program (NLN, 1994a).

The Associate Degree Nursing Program

Pioneered in the 1950's, the associate degree nursing program (ADN) has become part of one of the fastest growing educational movements in the nation. By 1993, the number of ADN programs reached 857. This type of education requires two years of full-time study, which leads to an associate degree and eligibility for RN licensure. The majority of programs are located in community or junior colleges, with a few in four-year institutions.

Traditionally, the focus of the curriculum has been on preparation for technical nursing practice. Programs include theory and some courses in the liberal arts and sciences along with supervised clinical learning. Over the years, however, associate degree nursing education has increasingly emphasized nursing subjects and clinical experience. Summer sessions have been added along with courses in team leadership and management principles. However, current NLN accreditation criteria for associate degree programs sets the standard of 72-76 semester credit hours as the maximum number for the degree.

As part of the system of higher education, ADN preparation awards college credit. New graduates are expected to practice primarily in staff-level positions, providing individual client care in structured environments such as hospitals and nursing homes. NLN's statement on the roles and competencies of ADN nurses provides guidelines identifying the expected level of practice at graduation and six months later (NLN, 1994c).

The Hospital Diploma Program

Long the mainstay of nursing education, hospital diploma programs, like their ADN counterpart, prepare their graduates to work as beginning practitioners in acute, intermediate, ambulatory, and long-term care settings (NLN, 1994e). Conducted by a hospital, this type of nursing preparation has evolved from an apprentice system to a more theoretical-based program with reduced clinical hours (Kalisch & Kalisch, 1986). While diploma pro-

grams are generally three years in length, many schools have adopted a shortened program.

Even before the movement toward higher education in nursing in the 1960's, hospital schools were beginning to close. By 1993, the number of programs dropped to 135. While some programs have contracted with colleges for general education courses, academic credit for nursing courses is not automatic when seeking a college degree. Since hospitals are not chartered to award degrees, graduates of diploma programs who wish to advance their careers must seek more formal study.

Other Entry Level Programs

The changing role of the nursing profession in the United States and its employment potential have drawn a new type of nursing student called a "second careerist". Several universities offer students who have a non-nursing degree an opportunity to earn a second baccalaureate, in nursing. These institutions give credit for prior college education and provide for advanced placement into the entry level BSN program.

An increasing number of schools also have initiated accelerated coursework, with some programs offering a full calendar year of nursing courses, five days a week. Consequently, it is often possible to complete an accelerated BSN program in one to one-and-a-half years of full-time study.

Another option for second careerists is an entry-level program that awards a master of science degree in nursing (MSN). These programs are often referred to as "generic master's" programs. Most of these programs take approximately three academic years and include a clinical specialty. Graduates are eligible to take the RN licensure examination.

In addition to the MSN-entry level program, three universities now offer a professional doctorate or the doctor of nursing (N.D.) degree to non-nurses with a bachelor or graduate degree in another discipline. Studies have shown that students pursuing a second career in nursing are more likely to stay in school, have a greater interest in research, score higher on standardized tests and licensure examinations, and continue their education. Many nursing leaders believe that these entry level programs represent the wave of the future in nursing education.

Novel Approaches to Nursing Education

In the 1970's, the NLN endorsed the concept of the open curriculum, which took into account the different purposes of the various types of educational programs while also recognizing common areas of achievement. The open curriculum seeks to permit student mobility according to ability, as well as changes in career goals and aspirations.

An example of this approach is the nursing program at Regents College (RC) of the State University of New York (formerly the Regents External Degree Program). The program's purpose is to meet the needs of graduates of diploma, associate degree, or practical nursing programs. It enables students to learn on their own, whether through individual study, work, travel, or other forms of life experience.

Regents College and other external degree programs offer a comprehensive system of assessment of college level knowledge and skills, and use a variety of evaluation procedures. Often referred to as a university without walls, RC awards an associate degree in nursing and a bachelor of science degree in nursing.

To promote more options for nursing education, many schools have introduced the career ladder approach, which provides direct articulation between nursing programs. Under this system, the student may "climb the ladder" from nursing assistant to practical nurse to associate degree nurse to baccalaureate nurse. For some, it means beginning at a basic level and moving one step at a time to the highest level. Others, however, can aim at a particular level and still be able to leave at certain exit points, become licensed, and practice according to the individual's credentials.

Baccalaureate education has generated a variety of other approaches to assist registered nurses seeking degrees. Among these are advanced placement through challenge examinations, selection of electives, modular learning, and independent or self study. Outreach programs have become popular vehicles for nurses located in isolated or rural settings. Flexible policies in associate degree education include open admissions, academic reinforcement resources, placement through examination, and autotutorial learning centers.

In 1991, the NLN reexamined its stance on educational mobility and developed a statement to replace its previous positions on this issue (NLN, 1991b). In its view, articulation arrangements between institutions, which indicate the coordination and recognition of program and course content (transfer credits) are efficient and effective methods to assure educational mobility of individual graduates. The NLN also believes that awarding of transfer credit should be based on course content and student outcomes.

The NLN has urged schools and programs in nursing to expand their present efforts by developing articulation arrangements that specify policies regarding the transfer of academic credits for graduates of identified programs. It further specifies the indices of the quality of nursing edu-

cation that should be addressed. At least 23 states have developed well-constructed articulation agreements to guide this process.

The NLN also believes that issues related to equal access and equality in the treatment of students, especially those from under-represented racial and ethnic backgrounds, should receive greater attention from nursing education. Given a diverse student population, multiple option entry and progressive pathways need to be accommodated to individual learner needs.

Some of the most creative innovations have been developed in graduate education for master's and doctoral students, particularly those working full- or part-time. Among the new options are on-campus weekend programs, intensive summer sessions, or one-day-a-week courses. Also available are satellite programs for individuals or groups of students from varied geographical areas.

Nontraditional forms of entry-level education must meet the same standards set forth by the profession. The programs are developed, controlled, and directed by qualified nurses, and include the evaluation of outcomes of expected competencies. Furthermore, such programs must maintain performance standards to protect both the student and the profession.

Diversity in Graduate Education

In the late 1970's, ANA recommended that the focus for graduate education in nursing be on preparation for diverse roles in master's, doctoral, and postdoctoral education. Among the roles cited were clinical nurse generalists or specialists, researchers, theoreticians, consultants, public policy makers, systems managers, and colleagues in multidisciplinary teams. A more recent statement by NLN on the characteristics of master's education in nursing was published in 1987 (NLN, 1987).

Like baccalaureate education, the number of master's programs in nursing continues to increase, reaching 243 in 1993 (NLN, 1994d). The programs vary, however, in admission requirements, organization of curriculum, length of the program, and costs. At this educational level, a significant number of students are preparing for careers in advanced nursing practice. Although nurse practitioner programs are growing, clinical specialization remains the favored track (NLN, 1994d).

Adult health/medical-surgical nursing is the most popular content choice for clinical specialists, while family practice ranks high among nurse practitioner students. The majority of nurse practitioners work in the community providing primary care.

Doctoral nursing programs have quickly multiplied, increasing from four in 1950 to 54 in 1993. Several types of doctoral programs have evolved which offer different degrees, including Doctor of Philosophy (PhD), Doctor of Nursing Science (DNS or DNSc), also known as the clinical doctorate, Doctor of Education (EdD), and others. Theoretically, the PhD is viewed as a degree that emphasizes the development of theory and basic research, while the clinical doctorate aims to use theory and engage in applied research. Regardless of the type of doctoral degree that nurses earn, they are expected to be qualified for teaching, research, and administration.

The changes in nursing practice and the growth of nursing education in institutions of higher learning have affected the supply and demand of qualified teachers. The issue is not merely the faculty shortage but the shortage of faculty educated as teachers in addition to their clinical knowledge. Present trends show markedly less interest among graduate nursing students in pursuing the teaching role as their major.

Main Elements of Education Standards

Education standards/criteria are developed by each NLN educational council. The criteria for the various types of programs have tended to reflect commonalities in areas to be addressed, such as structure and governance, curriculum, faculty, students, material resources, and program evaluation. After studying the criteria of all councils and with acknowledgement of commonalities across the councils, the NLN Board of Governors, in June 1995, approved the recommendation that Core Criteria be made the core and organizing accreditation criteria for all councils. However, councils may add criteria if approved by membership, and interpretive guidelines for each criterion may be developed to reflect the uniqueness of the council's level of nursing practice. The common Core Criteria contain the following sections: Mission and Governance, Resources, Faculty, Students, Curriculum, and Program Effectiveness, which includes outcome assessments (NLN, 1995a).

Until 1989, criteria from all councils were process oriented and included a systematic evaluation plan. In 1989, the U.S. Department of Education mandated that all accrediting agencies incorporate program effectiveness/outcome assessments into criteria. Each educational council met this charge by incorporating the two mandatory criteria: graduation rates and employment rates. The Council of Baccalaureate and Higher Degree Programs revised their criteria, moving from a content prescriptive approach to curriculum to an outcome evaluation approach. Five required outcomes are included: critical thinking, communication, therapeutic nursing interven-

tions, graduation rates, and employment rates. Two additional outcome criteria are to be selected from a list of eight optional criteria and outcome data are to be reported on all outcomes addressed in the self study. Additionally, professional nursing standards congruent with the mission of the program are to be incorporated and utilized in the curriculum.

With the Core Criteria as an organizer across councils, the structure of criteria are now more similar than different. However, each Council's uniqueness is still clearly identified through its interpretive guidelines.

As stated earlier, rules for Boards of Nursing include standards related to organization and administration, curriculum, faculty, resources, evaluation, performance and graduates. Similarities are easily identified between the elements of the standards of accreditation and regulation. Differences arise in the development of standards and the processes for monitoring and changing standards/criteria.

Impact of Education Standards

Nursing has a long history of voluntary efforts to raise its education standards. As a result of these efforts, education standards developed at the state and national levels have had a significant influence on the quality of nursing education and practice throughout the United States. High education standards have facilitated the movement of nursing education programs into higher education settings. Education standards continue to provide for the maintenance and enhancement of educational quality, provide a basic assurance of program improvement, and contribute to the improvement of nursing practice.

Many strengths derived from the standards of Boards of Nursing. They include uniform standards and guidelines for nursing education within the jurisdiction, as well as the facilitation of educational and practice mobility. Standards also provide a means for evaluating international applicants. Most importantly, the standards assure that all candidates taking the national licensing exam have graduated from an approved school.

Funding Sources for Nursing Education

While funding for nursing education has declined in recent years, some federal and state resources continue to help nursing students acquire an education. Most financial aid for nursing education comes from the school itself, which usually administers government funds. Also, many colleges and universities offer their own financial packages. Other funding resources include community groups, private foundations, and professional organizations, which target scholarships and loans for specific purposes and recipients.

Almost all government assistance is based on student need, although some merit-based programs exist. Financial aid based on merit is awarded for outstanding academic achievement and other special qualifications set by the grantor.

Scholarships and fellowships (a grant for graduate education) do not have to be repaid, nor do traineeships, which are federal stipends and tuition grants. Some schools offer work-study programs that allow students to work and earn money for school. The NLN carries a comprehensive and up-to-date listing of sources for funding for nursing students in undergraduate and graduate programs (NLN, 1995b).

Ten-Year Projections for Standards of Nursing Education

"Changing" is the best word to describe contemporary nursing in the United States. Such an observation is not surprising in light of the dynamism of the entire health field over the past few decades. People live longer as a result of earlier diagnosis and treatment, healthier lifestyles, self-care programs, and a greater exposure to health information. Technology continues to forge new diagnostic and treatment approaches that continuously influence nursing practice.

Not all developments, however, are positive. Automobile accidents, homicides, substance abuse, mental depression and anxiety disorders, and adolescent sexual activity are on the increase. Teenage pregnancy has contributed to a birthrate that is higher in the United States than in many developed countries. Sexually transmitted diseases, including HIV and AIDS, are currently reaching epidemic proportions. Another public health threat, linked to AIDS, homelessness and drug abuse, is the re-emergence of tuberculosis. All of these concerns create enormous challenges for the health professions, particularly nursing.

Health Care Trends Influencing Nursing

More than two million registered nurses are on record in the United States, with over 80 percent employed. Two-thirds of this large contingent work in hospitals, but an increasing number is shifting to community-based care (Moses, 1992). Approximately 250,000 RN's now work in state or local health departments, non-hospital based home health agencies, community nursing centers, occupational health, and other areas.

Nurses also teach in schools of nursing, serve in executive positions, conduct research, and share joint practices with

other nurses or physicians. As these trends continue, the number of men being drawn into nursing is also increasing.

Hospitals have experienced a marked decline in census over the past decade, and are expected to continue to "shrink" and restructure in the future with the focus primarily on acute and critical care. To cut down on expensive hospitalization, many procedures have been successfully performed in the ambulatory care department, where one-day surgery has become almost commonplace.

Another effort to make hospital care more cost- effective has been the introduction of prospective payment systems since the early 1980's. Under this arrangement, the federal government, which provides funding to hospitals for Medicare and Medicaid patients, has designated a predetermined length of stay according to the diagnosis-related group (DRG) in which the person has been categorized. As a result, patients have been discharged more rapidly, and often require complex and highly technological care in the home.

Also affecting hospital stays is the growing popularity of health maintenance organizations (HMO's), which represent one type of managed care. Managed care is a health-care delivery system that uses active risk sharing in economic gains and losses to provide the best value in health care for a defined group of enrollees or members of a plan. HMO's combine the delivery and financing of services, which may be provided in facilities owned by the HMO (usually for ambulatory care), or through contractual agreements with hospitals. The health maintenance organization aims to avoid hospitalization which is the most expensive component of the health care industry.

For decades, nurses have provided care in a variety of clinics located in the outpatient departments of hospitals. In recent times, however, the structure and operation of these clinics have undergone dramatic change. A number of outpatient facilities now house large, specialized centers, in which nurses coordinate the plan of care with other health care workers, and arrange support groups according to the person's diagnosis and needs.

Ambulatory care nursing also involves nurses working in specialized services as well as in comprehensive services. One area that has undergone significant change is same-day surgery, in which ambulatory care nurses assume responsibility for educating and preparing patients in advance of their pending operation.

Internationalization and cultural diversity continue to grow in the United States. Enrollment of international students continues to rise. As population statistics shift, health care professionals are needed to provide culturally congruent health care. Schools of nursing are faced with educational and pedagogical issues relating to the presence of diverse student populations. Admission standards that are equitable and the need for licensure for graduate study also continue to be issues.

In summary, "change" will continue to describe the state of health care and nursing in the next ten years. The trends described in this section will be influencing variables as standards are reviewed and set. The challenge will be to establish and maintain education standards amidst this change.

Emerging Regulatory Issues Related to Standards

One of the most challenging regulatory issues related to education standards is how to educate nurses for the fast-changing health care system and maintain quality programs. A community-based educational program will be faced with many challenges as faculty develop programs and clinical experiences in a different context. Supervision of students, the appropriate use of technology in monitoring students, and faculty- student ratios as related to education standards will be at issue. The NCLEX, currently based on job analyses conducted in hospital settings, will need revising. Research continues on computerized adaptive testing and interactive computerized testing. Data from this research will lead to decisions about testing in the future.

Technology is likely to bring additional issues related to regulation. With the advent of telemedicine and telenursing, legal issues about licensure to practice in areas accessible mainly through technology will surface. For example, is a nurse practicing in one state legally covered to provide nursing care through a technological system to a patient in another state? It is impossible to anticipate all of the regulation issues that are likely to surface in the future.

Entry into professional nursing continues to be an issue and will be shaped by education standards developed for the future. Professional nursing organizations support the baccalaureate degree as the entry level into professional nursing. Organizations such as the Pew Health Professions Commission continue to study and make recommendations for the health professions and nursing will be impacted by these reports.

The NLN will continue to be affected by the rules and regulations set forth by the U.S. Department of Education. Under current review, major structural changes in the NLN accreditation section will be sent to the membership for vote in the near future. Political changes will continue to affect the Department of Education and thereby the agencies approved as accrediting bodies.

Boards of Nursing are also faced with challenges. As nursing education programs change, regulatory bodies will need to be flexible and responsive, while also maintaining

quality. Participation of faculty, practitioners, and consumers will be essential as decisions are made related to the first professional degree, community-based education, unique and diverse clinical experiences, and increased technology.

While it is impossible to anticipate all of the challenges that await in licensure and accreditation, it is clear that maintaining education standards will be critical. The road to the future will be dynamic, complex, and challenging.

Anticipated Changes to Elements and/or Content of Standards

With the recent acceptance of mandated outcome assessments and Core Criteria as a basis for structure, it is not anticipated that changes in the elements and/or content of NLN accreditation criteria will change in the near future. As stated earlier, the NLN will respond to changes in the rules and regulations set out by the Department of Education which may modify accreditation policies and procedures as well as the criteria in specific ways. The seventh edition of *Policies and Procedures of Accreditation for Programs in Nursing Education* will be published in the summer of 1996. Revised manuals of accreditation criteria based on Core Criteria structure will be published by each educational council by the fall of 1996.

Process for Changing Standards

Changes in accreditation result from ongoing review and intensive study based on the philosophy and purposes of the NLN accreditation program. The membership of each of the educational councils of NLN, the NLN Board of Governors and the public provide continuous review and study of the accreditation process and the criteria for accreditation. Changes are suggested within councils and recommended to the NLN Board of Governors through the Committee on Accreditation. The Board of Governors has the final authority in relation to overall policies and uniform procedures. Criteria for program evaluation are determined by the individual councils and voted upon by membership before implementation. With anticipated changes in structure of the NLN, the process for changing standards will be affected.

Nurse Practice Acts authorize the Boards of Nursing to regulate nursing practice. Revision of rules and regulations are developed by the Boards to reflect changes in the roles of nurses and need for safe nursing practice. Changes in rules and regulations are a public action and must comply with the laws of the jurisdiction.

Future Challenges in United States Standard Setting

As American nursing approaches the 21st century, the consumer will require both acute and primary care services. A higher level of sophistication will be expected of nurses as the knowledge base in science expands and the health care environment relies increasingly on technology.

The use of computers has already had a marked impact on organizational structures such as hospitals, and will continue to be used in the development of new management systems. Nurses play a pivotal role in these systems and therefore must become increasingly knowledgable about computers. They will be expected to plan, design, standardize, and evaluate the nursing database. In many undergraduate programs, nursing informatics courses have been initiated, and in some cases are required.

If nurses wish to be major players, and indeed to survive, their accountability will rest on a knowledge-based credentialing system. As responsible professionals, they will have to expand their vistas to embrace other agendas, particularly those more concerned with social policy and issues related to the general quality of life.

In organized nursing's plan, featured in *Nursing's Agenda for Health Care Reform* (NLN, 1992c), a prominent role is seen for nurse practitioners. A new approach to health care delivery is suggested with the profession's proposal for a consumer-driven, community-based system of primary care providers.

In 1993, the NLN Board of Governors endorsed a two-year plan for nursing education reform that was developed by a blue ribbon panel appointed by the organization's president. The panel's charge was to launch a campaign pointing the way for strategic direction in nursing education. The most critical question to be addressed was: What has to be done to achieve "real change" in nursing education over the next two years in order to assure that community-based care will become a reality in our communities around the country?

The campaign intends to feature a series of funded demonstration sites showcasing community-based nursing education. Several activities will be launched, including the creation of partnerships between schools and community agencies. In short, nursing education will be reframed so as to:

- Ensure ethnically and culturally diverse faculties and students;
- Position caring as the foundation of nursing practice;
- Balance the art of nursing with its science;

- Promote leadership and accountability in students, graduates and faculty; and
- Include community partnerships as basic and integral to the educational enterprise.

A major change has occurred in the characteristics of today's healthcare consumer, with the influx of immigrants requiring new understandings of health care practices. This trend is expected to increase. Educational institutions must help nurses to meet these challenges since contemporary health care involves people from multicultural and multiracial groups with differing values, interests, and language.

Cognizant of existing as well as future health care reform, regulatory bodies will need to ensure that education standards are up-to-date with the newer and projected developments. An expanded range of competencies is proposed that will not be discipline specific, but rather interdisciplinary. The growing trend of professional nursing programs being located within health science centers creates the potential for greater communication and collaboration among health professional students and faculty.

The education councils of the National League for Nursing recognize the importance of relevancy when reexamining accreditation criteria. According to NLN's *A Vision of Nursing Education* (NLN, 1993a), the focus of education must turn from content to five significant areas: (1) critical thinking, (2) skills in collaboration, (3) shared decision making, (4) social epidemiological viewpoint, and (5) analysis and intervention at the systems and aggregate levels.

In the realm of government regulation of standards, state Boards of Nursing also endeavor to maintain quality control. Anticipated changes in the health care environment affects the curricula in nursing education, and Boards of Nursing will therefore have to be circumspect in their approval of new basic programs. In addition, Boards will be expected to review their Nurse Practice Acts in light of the anticipated and emerging roles of nurses.

Consensus building among the key nursing leaders and groups involved will be necessary to effect reform in educational standards and thereby advance professional nursing. The process will be an educational one, providing data about projected changes in the health care arena, such as supply and demand of nurses, new practice modalities, community demographics, costs, and other major factors.

Critical to reaching unanimity on education standards are two essentials: identifying the goals or outcomes to be achieved, and involving in the decision-making process the chief players to be affected by the changes, e.g., educational institutions, faculty, students, nurses, regulatory agencies, professional organizations, and consumers.

The cross-border movement of nurses to and from the United States requires an in-depth exploration of each nation's nursing education system, modalities of entry into practice, credentialing mechanisms, employment trends, and practice patterns. It is the expectation that the present document will provide insight into these areas, by offering some perspective on the past, present, and future development of United States nursing education standards.

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Similarities and Differences in Standards of Nursing Education in Canada, Mexico and the United States

The papers in Part One detail the Standards of Nursing Education in Canada, Mexico and the United States. Listed below are the similarities and differences found among those countries' practices. The topics that are compared include governmental regulatory authority; role of beginning nurse, nursing education standards, nursing education programs/entrance requirements; and future trends and issues.

GOVERNMENTAL REGULATORY AUTHORITY		
Canada	**Mexico**	**United States**
Yes	Yes	Yes
Standards of Nursing Education	Standards of General Education	Standards of Nursing Education
• Supported by law delegated to Provincial Nursing Association or regulatory body	• Supported by law administered by government agency (SEP) and by universities due to their autonomy	• Supported by state law most often delegated to State Boards of Nursing; in a few cases it is delegated to the State Board of Education
• Provincial not Federal Level	• Federal and State Level	• State not Federal Level
• Nursing and Education Focus	• Education not particularly Nursing Focus	• Nursing and Education Focus

ROLE OF BEGINNING NURSE AS DICTATED BY MINIMAL EDUCATION STANDARDS		
Canada	**Mexico**	**United States**
• Generalist Nurse	• Generalist Nurse (may be trained in one speciality area more than others)	• Generalist Nurse
• Provider of care, coordinator of care, client advocate, member of profession	• Direct caregiver, administration, care co-ordinators, scientific knowledge users	• Provider of care, coordinator of care, client advocate, member of profession
• Nursing practice in medical, surgical, pediatric, maternity and psychiatric settings	• Nursing practice in medical, surgical, pediatric, maternity and psychiatric settings	• Nursing practice in medical, surgical, pediatric, maternity and psychiatric settings
• Community as client - BN only - Employer hiring standards vary	• Community as client - BN preferable - Employer hiring standards vary	• Community as client - BSN only - Employer hiring standards vary
	• The technical nurse practices in the same roles as the BN-prepared nurse and both obtain the same license to practice nursing. However, the education of the technical nurse is comparable to the LPN in the United States or RNA/LPN in Canada	
• BN/BScN consumer of research	• BN consumer of research	• BS/BSN consumer of research

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NURSING EDUCATION STANDARDS – MODELS/APPROACHES

Canada	Mexico	United States
• Nursing associations/ regulatory bodies use structure, process and outcome model but moving toward outcome based processes/standards	• The State sets the general standards of education; nothing specific about nursing (i.e., primarily based on number of credits/hours)	• State sets nursing education standards using structure, process and outcome model. The development of outcome based processes/standards is at a beginning level
• Well developed	• Well developed general standards	• Well developed
• Mandatory	• Mandatory general standards	• Mandatory
• Each province sets own standards but fairly uniform across provinces	• Government delegates standards implementation to universities - university standards for nursing education are defined in the schools, starting from General Education Standards and university legislation • Nursing organizations developed standards for nursing education. They are not regulated by law and therefore, are not mandatory	• Each state sets own standards but fairly uniform across states.
• Same standards for Diploma and BN/BScN programs in most provinces	• Nursing Standards need to be reviewed and made mandatory - primarily use a structure and process model • Are voluntarily used by university schools • Technical Schools associated with universities (approx. 50%) follow nursing standards	• Some states have differential standards for Diploma, AD, BSN
• Voluntary National Accreditation (CAUSN) - for BN/BScN programs only	• No accreditation process for nursing schools and programs	• Voluntary National Accreditation (NLN) - Differential criteria for Diploma, AD, BSN - Outcome model
• Some provinces specify minimal hours of theory and practice	• Minimal hours of theory and practice are specified by the educational institution according to academic level	• State variability in minimal hours of theory and practice, if specified at all

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NURSING EDUCATION PROGRAMS/ENTRANCE REQUIREMENTS

Canada	Mexico	United States
• Diploma - 2-3 yrs - hospital (few) and college based (majority)	• Technical - 3 yrs, plus 6 months to 2 yrs community service - private schools - some associated with universities (approximately 50%) and are higher quality	• Diploma - 2-3 yrs - hospital based
		• Associate Degree (AD) - 2-3 yrs - junior colleges (majority)
• BN/BScN - 4 yrs - university - nursing content starts year I	• BN - 4 yrs, plus 6 months to 2 yrs community service - university and institutions of higher learning - nursing content starts year I	• Baccalaureate (BSN) - 4 yrs - senior colleges and university - upper division nursing courses, most start in year III
• MN(1) - prepares entry level nurses - prior degree for entrance	• No entry level above BN	• Approximately 20 generic Masters (MSN) and 3 doctoral (ND) programs prepare entry-level practitioners for advanced practice and research - prior degree(s) for entrance
Entrance Requirements	**Entrance Requirements**	**Entrance Requirements**
• Diploma - 12 yrs prerequisite school/education	• Technical - 9 yrs prerequisite education (ie. no high school)	• Diploma, AD and BSN - 12-13 yrs prerequisite school/education
• BN/BScN - 12-13 yrs school (most) - 2 Provinces: 1 yr university - 1 Province: 2 yr university	• BN - 12 yrs prerequisite education	• BSN - 2 yrs senior college for admission to upper division nursing courses
• Programs specify course requirements - (math/science/language)	• No specific course requirements	• Programs specify entry-level course requirements - vary by program type
• Competitive admission thus enroller exceeds requirements	• Competitive admission	• Competitive admission thus enroller exceeds requirements for BSN
• A grade point average, established by individual schools, must be achieved by students to progress in program	• A grade point average, established by individual schools, must be achieved by students to progress in program	• A grade point average, established by individual schools, must be achieved by students to progress in program

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FUTURE TRENDS AND ISSUES		
Canada	**Mexico**	**United States**
• Concerns about costs are redesigning work environments and increasing the skill mix to provide care, resulting in blurring of role boundaries in health care	• Health Sector reforms indicate that Social Safety and Health Secretariat institutions will increase the efficiency and quality of services. This involves reorganizing health expenses to seek a more equal delivery of better health services to more Mexicans	• Concerns about costs are redesigning work environments and increasing the skill mix to provide care, resulting in blurring of role boundaries in health care
• Jobs scarce with unemployment common	• No unemployment but a trend toward it, since personnel without a nursing education are hired to perform nursing duties at lower cost. Nurses may also have two nursing positions/employers	• Jobs available in many areas of the country but limited in selected urban areas. Wider range of settings available
• More health care services moving to community settings with minimal anticipated job increases	• Second and third level hospitals employ the highest number of professional nurses even though there is a trend to expand professional nursing care into the home	• More health care services moving to community settings with minimal anticipated job increases
• Acute care settings becoming more complex and specialized	• Acute care settings becoming more complex and specialized	• Acute care settings becoming more complex and specialized
• Many, not all, provinces requiring BN for entry to the profession	• BN programs increasingly in demand	• Diploma programs being phased out
• BN/BScN programs increasing focus on assessment and use of data to develop care decisions based upon cost and effectiveness (outcome measures)	• BN programs increasing focus on assessment and use of data to develop care decisions based upon cost and effectiveness (outcome measures)	• BSN programs increasing focus on assessment and use of data to develop care decisions based upon cost and effectiveness (outcome measures)
• Nursing practice based upon research	• A beginning trend toward the promotion of nursing practice based on theory and research results	• Nursing practice based upon research
• Increase culturally appropriate content within curriculum and recruit students from more diverse backgrounds	• Increase culturally appropriate content within curriculum and recruit students from more diverse backgrounds for BN programs	• Increase culturally appropriate content within curriculum and recruit students from more diverse backgrounds
• Separation between practice and education narrowing: joint positions and praxis to be norm	• Separation between practice and education narrowing: joint positions and praxis to be norm - integrating teaching, service and research	• Separation between practice and education narrowing: joint positions and praxis to be norm

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Recommendations

Standards of Nursing Education in Canada, Mexico and the United States

The following recommendations, based upon comparison of the Standards of Nursing Education of the participating trilateral countries, are offered to further connect North American nursing education standards and therefore realize the goals of the Trilateral Initiative.

1. It is recommended that a detailed comparative analysis be conducted in each country on:
   - the standards that regulate nursing education, that is, comparing the standards of each American state, Canadian province, and Mexican General Government (SEP) and University Standards;
   - other standards that guide the development of nursing education programs (for example, accreditation standards, national nursing education standards);
   - the differentiated competencies achieved in the various nursing educational pathways/levels for entry to nursing practice; and
   - future trends and the specific impact on education standards and nursing programs in the future.
2. It is recommended that a collaborative trilateral process be pursued to facilitate the attainment of a nursing regulatory role in Mexico that includes:
   - standardization of nursing education;
   - upgrading the academic level of faculty; and
   - unifying academic entrance requirements for entry to technical/basic nursing programs.

Part Two

Approval and Accreditation of Nursing Education Programs in Canada, Mexico and the United States

Part Two focuses on the processes of approval and accreditation of nursing education programs in the three countries. For the purposes of this document, "approval" is defined as a legal process for the review of educational programs to ensure compliance with minimum nursing education standards. "Accreditation" is a review and assessment process whereby educational institutions and/or programs are recognized for quality when reviewed against predetermined standards or criteria established and measured by peers. While approval processes are mandatory, focused on minimum standards, and based at the province, territory or state level, the accreditation process is voluntary, focused on excellence, and generally conducted by national professional associations. To the extent that it can be determined that standards of education are comparable, it will not be necessary to examine each individual program within the three countries. The identification of differences, meanwhile, provides an informed basis for working toward mutually acceptable standards.

Chapters describing these processes in Canada, Mexico, and the United States, respectively, are followed by a summary of similarities and differences among the three countries. In the United States, an example of a nursing specialty program, Accreditation of Nurse Anesthesia Education Programs, is also presented. These assessments are followed by a summary of similarities and differences among the three countries. Finally, recommendations are offered aimed at working toward increased trilateral understanding and mutually acceptable standards for approval and accreditation processes.

Approval of Nursing Education Programs in Canada

Marlene Smadu, RN, EdD
Canadian Nurses Association

Executive Summary

Nursing education programs are regulated in the public interest. Concern by government and nursing organizations regarding the need for quality nursing education has been evident since the time nursing education programs began in Canada. One of the key purposes for seeking nursing legislation in provinces/territories was to set standards for nursing education. Historically, standards/criteria used to evaluate nursing education programs for purposes of approval emphasized structures, processes, and resources of the nursing education program.

In Canada, the responsibility for the regulation of health professions rests with the provincial/territorial governments. In most jurisdictions, the responsibility for the approval of nursing education programs is delegated to professional self-regulating bodies through legislation. Key exceptions to this are the jurisdictions of Alberta, Ontario, and Quebec. Recently, some jurisdictions have begun to use outcome-based standards and criteria to enhance accountability to the public. Other jurisdictions, particularly those that have moved to baccalaureate-only preparation for entry into nursing practice, have incorporated the findings and/or reports of the Canadian Association of University Schools of Nursing (CAUSN) accreditation process into the approval process.

Major strengths of the approval processes in Canada are the protection of the public and the growth and improvement in nursing education programs. Another strength is the profession's leadership in setting the standards for nursing education. Weaknesses include concerns regarding who defines "minimum" standards for education, the use of the same standards for diploma and baccalaureate programs, and the existence of different standards and criteria for approval in different jurisdictions. In addition, education standards that are too narrowly or rigidly defined could lead to stagnation of the nursing education programs.

Trends in regulation indicate governments' interest in delegating regulation to the private sector and in preventing over-regulation by professional bodies while still ensuring the public's best interests. This concern could lead to changes in legislation regarding self-regulating professional bodies in general. Because of recent national and international trade agreements, governments are very interested in national standards for professionals, including standards for education. This interest may extend to how nursing education programs are approved, and by what standards. Increased emphasis on evaluating outcomes of programs helps to prevent over-regulation by self-regulating professional bodies while reaffirming the mandate for protection of the public.

History of Approval Processes

Background, Dates, and Structures in the Establishment of Approval Processes

Key Factors

Nursing education programs are regulated in the public interest. Concern by government and nursing organizations regarding the need for quality nursing education has been evident since the time nursing education programs began in Canada. One of the key purposes for seeking nursing legislation in provinces/territories was to set standards for nursing education.

The first hospital diploma nursing program was started in 1874, while the first university nursing program began in 1919. In 1927, a joint committee of the Canadian Medical Association (CMA) and the Canadian Nurses Association (CNA) was established to study problems in nursing education, particularly those associated with programs being run out of service organizations. Dr. George Weir, from the Department of Education at the University of British Columbia, was appointed to lead the study. The Weir Report (1932) was a comprehensive report on Canadian nursing education and made recommendations regarding organizing, financing and standardizing nursing education programs. One of the key recommendations was that schools of nursing become part of the general education system, with appropriate related funding.

Over the next 30 years, a number of reports were published that recommended that basic nursing education be transferred from hospitals to educational institutions. In 1960, Helen Mussalem's CNA-sponsored review of diploma nursing schools in Canada, entitled *Spotlight on Nursing Education*, was released. Mussalem recommended that the entire field of nursing education be reviewed before establishing an accreditation program, since problems continued to arise from the practice of running educational programs out of service-oriented institutions.

Reflecting on the work of Weir and Mussalem, the Royal Commission on Health Services recommended in 1964 that a Nursing Education Planning Committee be established in each province, with one of its mandates being "to examine the process of nursing education standard setting, inspection and enforcement, and to make recommendations which improve the process". Significant discussion has taken place through the years involving government and nursing organizations regarding preparation of nurses in diploma versus degree programs, in educational settings versus hospital-based facilities, and regarding funding and length of programs.

Key Organizations

Because the responsibility for the regulation of health professions in Canada rests with the provincial/territorial governments, provincial/territorial departments of health, education, labor and others have been involved in discussions regarding the quality of graduates from nursing education programs. In most jurisdictions, responsibility for the approval of nursing education programs is delegated to nursing self-regulating bodies through legislation.

Nationally, the CNA has been involved in issues regarding nursing education since its formation in 1924. CNA's involvement has included sponsoring reviews and forums, developing formal Standards for Nursing Education (Canadian Nurses Association, 1978), producing materials related to the position of baccalaureate entry to practice (e.g., Canadian Nurses Association, 1982), developing position statements, and lobbying for graduate education.

Stated Objectives

The objective of the approval processes in Canada is to ensure that the nursing education program is capable of preparing graduates able to meet the standards and competencies required of the nurse entering practice.

Key Features (mandatory, national or provincial/state level, regulated by government or profession).

The approval of nursing education programs is mandatory in all jurisdictions in Canada. In most jurisdictions, the approval process is carried out by the provincial/territorial nursing self-regulating body, which generally forwards a report to the appropriate government department and/or has government representation on an Approval Committee.

Minimum standards are established against which the program is measured. Programs must reflect a nursing model, the scope of practice, competencies for beginning practice, nursing practice standards and code of ethics of the provincial/territorial association and/or CNA. While approval addresses minimum standards, accreditation focuses on higher standards.

Key Exceptions

Three jurisdictions in Canada do not directly delegate the approval process to the nursing self-regulating body. In Alberta, all programs leading to nursing registration are regulated by the Universities Coordinating Council. In Ontario, the Ontario Region of the Canadian Association of University Schools of Nursing (CAUSN) is responsible

for approval of baccalaureate nursing education programs. The Council of Standards and Accreditation, an agent of the Ministry of Colleges and Universities in Ontario, approves diploma nursing education programs in the Colleges of Applied Arts and Technology. In Quebec, all post-secondary education, including nursing programs, is governed by the Ministry of Higher Education and Science. The nursing self-regulating bodies in Quebec, Ontario, and Alberta have input into the development of the standards by which nursing education programs are measured.

Outline of Initial Processes

Steps/Stages of Processes

Historically, in most jurisdictions, standards/criteria evaluated during the process of approving nursing education programs addressed the following areas: administration and general organization, philosophy and objectives, faculty, students, curriculum, educational resources and facilities, records and reports, and evaluation. The emphasis tended to be on structures, process, and resources of the program. The approval process generally included the development of a report by the nursing education program to address the various standards and criteria against which it was being measured and an on-site visit to the program conducted by one or more expert nurse educators/nurse administrators/evaluators.

Time Frame

In most jurisdictions, approval was required prior to establishing a new nursing education program. Once initial approval was granted, monitoring for continued approval generally occurred at five-year intervals.

Key Actors in Processes

Several key actors have been involved in the approval process. Generally, the nursing self-regulating body set the standards for approval of nursing education programs, facilitated the review process, and made the final decision regarding the approval status of the nursing education program. The nursing education program developed a report or submitted documentation describing how the program met the standards for approval of the regulating body and hosted the on-site visit. Expert evaluators, sometimes external to the jurisdiction, conducted an on-site visit to the nursing education program and developed and presented a report of findings to the self-regulating nursing body. Provincial/territorial governments received the report from the self-regulating nursing body regarding the status of approval of the nursing education program and/or had representatives on the Approval Committee.

Major Changes in Processes Over Time

Nature of and Reasons for Changes

Standards for approval of nursing education programs in some jurisdictions have been refocused from structures, processes and resources within the nursing education program to the outcomes of the programs, i.e., the graduates (See Appendix A). This shift has occurred because of the increased emphasis on accountability to the public by self-regulating professional bodies as a result of health reform and other trends in society emphasizing increased accountability.

Some jurisdictions that have or will soon have only baccalaureate nursing education programs are incorporating reports and/or findings from the CAUSN accreditation process into the approval process. The minimum level of nursing education program eligible for CAUSN's accreditation program is the baccalaureate program. The integration of the accreditation process into the jurisdiction's approval process, while having a different mandate and focus, is seen to conserve human and financial resources.

Current Status of Approval Processes

Description of Current Approval Processes

Steps/Stages of Processes

In those jurisdictions where approval of nursing education programs is conducted by the nursing self-regulating body, most or all of the following steps are included in the approval process:

1. Notification to the program of impending approval;
2. Development of a self-evaluation report or compilation of program documentation by the nursing education program based on the standards for approval;
3. On-site assessment visit conducted by one or more expert assessors and development of an on-site visit report;
4. Review by the self-regulating nursing body of the program's self-evaluation report, the on-site visit report, and other documentation/presentations;
5. A decision is made about the status of the program by the self-regulating nursing body and communicated to the nursing education program and government. The communication often includes identification of the program's strengths and areas for improvement;
6. Interim reports and reviews may be required when areas for improvement are noted and required to meet criteria (See Appendix B and Appendix C for examples of the steps of the approval process in two jurisdictions).

Time Frame and Milestones

The maximum duration of approval generally ranges from four to seven years. Some jurisdictions give approval for shorter periods of time, particularly if deficits are noted.

Authorities and Structures

With the exception of those jurisdictions noted in the section on "Key Exceptions", provincial/territorial self-regulating nursing bodies have the authority to approve nursing education programs for purposes of nurse registration. Much of the approval process work is handled through committees within these nursing bodies. Provincial/territorial governments approve the programs for purposes of funding and acquisition of resources.

Decision and Appeal Processes

The decision regarding approval status is generally made by the governing council of the self-regulating nursing body. There is generally an appeal process established that allows for independent review of the process and decision.

Monitoring and Evaluation Mechanism

Some of the provincial/territorial self-regulating nursing bodies are beginning formally to incorporate an evaluation of the approval process for each approval review conducted. The evaluation incorporates information gathered from the stakeholders involved in the approval process, such as program administration and faculty, students, employers, graduates, on-site assessors, and approval committee members.

Key Exceptions

The key exceptions are the jurisdictions of Alberta, Ontario and Quebec, as described in the section on "Key Exceptions" under "History of Approval Processes."

Strengths and Weaknesses of Current Approval Processes

Perceived Strengths of Processes

A number of strengths of the approval processes have been identified. First, the protection of the public, which is the mandate of self-regulating nursing bodies, is enhanced by evaluating the nursing education programs that prepare nurses for beginning nursing practice. Increased emphasis on outcomes, rather than only structures and processes, highlights the need for nursing education programs to be accountable for the graduates of their programs. As well, the approval processes support the development of nursing education and the identification of competencies required for entry into practice. Still another strength of the approval processes is that the profession of nursing sets standards for nursing education against which the programs are measured.

Perceived Weaknesses of Processes

A number of weaknesses of the approval processes have been identified. First, questions have been raised regarding who decides what "minimum" standards are, and whether evaluating against minimum standards, rather than evaluating for quality of programming as is the mandate of the accreditation process, is sufficient. Other weaknesses include the fact that in most jurisdictions, diploma and degree programs are evaluated using the same standards, and also that different standards, criteria, and processes for approval are used in each of the jurisdictions. There is concern that if standards for nursing education programs are defined too narrowly and rigidly by the nursing self-regulating body, opportunities for creativity and change may be missed by the nursing education programs. Finally, questions have been raised regarding whether the approval processes measure the extent to which graduates meet the needs of the health care system.

Impact of Approval Processes

Incentives for Undertaking Approval Processes

The approval of nursing education programs at the provincial/territorial level is mandatory in Canada, with the ultimate purpose of protecting the public. An externally-conducted evaluation of the program provides opportunity for growth and improvement.

Number of University Schools/Faculties Approved/Not Approved

Programs in Canada must be approved if graduates are to be eligible for licensure/registration as registered nurses, so all nursing education programs are involved in an approval process.

Implications of Non-Approval

If a nursing education program were not approved, it would indicate that the public could not be guaranteed a certain standard of educated professional. As well, graduates would not be eligible to register with the provincial/territorial self-regulating nursing body. The fact that nursing education programs are government-funded means there is generally a commitment to address deficits or weaknesses identified in an approval review in a timely

manner, thus avoiding a rating of "approval denied" at some future date.

Measured Improvements in Nursing Education as a Result of Approval Processes

Improvements in nursing education resulting from the approval processes include greater consistency in the outcomes of nursing education programs within a jurisdiction, and assurance that graduates meet minimum requirements. In addition, sharing of information among nursing education programs occurs, and consultation with the nursing self-regulating body is available.

Projections for Approval Processes Over Next Ten Years

Status of Approval Processes

Recognition by Government

Generally, trends in regulation indicate governments' interest in delegating regulation to the private sector and in preventing over-regulation by professional bodies while still ensuring the public's best interests. Changes in legislation regarding self-regulating professional bodies have occurred recently in Ontario and British Columbia, and are in process in other jurisdictions, including Alberta, Manitoba, and Nova Scotia. The Manitoba Law Reform Commission (1994), for example, presents a model of professional regulation that stresses "a careful consideration of all the costs and benefits of a particular regime before its implementation, a decision on the form of regulation prior to a decision as to the administration of the regime, greater government supervision of self-governing bodies and more public access to and involvement in occupational regulation" (p. 104). As a result of recent national and international trade agreements, governments are very interested in national standards for professionals, including standards for education. This interest may extend to how nursing education programs are approved, and by what standards.

Support from Universities/Schools/Faculties

Nursing education programs and their institutions are required to participate in an approval process. Findings of the approval visit can be used to the school's advantage in securing additional resources or in maintaining existing ones. With decreasing resources for education in general, nursing education programs will demand efficient, effective approval processes.

Proposed Modification/Expansion/Deletion to Current Processes

Jurisdictions that have revised their approval processes to place increased emphasis on evaluating outcomes of the programs believe that this modification will prevent over-regulation by the self-regulating professional bodies and reaffirm their mandate to protect the public.

Jurisdictions that are using, or planning to use, CAUSN accreditation reports as part of the documentation for the approval process believe this move will save the nursing education program's time, energy, and other resources, and could decrease expenses of the provincial/territorial associations in conducting the approval review. However, some of these jurisdictions acknowledge that the integration of the CAUSN accreditation process with the self-regulating professional body's approval process could be more easily accomplished if the CAUSN process were more outcome-oriented and related to provincial/territorial standards.

International Interest in Approval Processes

Types of Requests for Information or Consultation

Regulatory bodies from other countries request information on the process/standards/criteria for approving nursing education programs to determine the equivalency of the graduates of the programs to graduates from their own jurisdictions.

Level of Activity in International Arena

Recent requests for information from other countries have been stimulated by the changes that are occurring in nursing education programs throughout North America, Asia, Australia, and New Zealand related to the curriculum revolution and health reform.

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Appendix A

Approval of Schools of Nursing Criteria and Indicators

Registered Nurses Association
of British Columbia

Guidelines

Indicators for each criterion may be used by educational institutions in preparing the self-evaluation report. The educational institution may use additional indicators, as the list provided is not considered exhaustive.

Criterion 1. The curriculum provides learning experiences necessary for students to achieve professional practice requirements.

Indicators

1. Objectives and goals of the curriculum reflect the standards for nursing practice in British Columbia and the nursing competencies and skills required of the new graduate.
2. The curriculum plan operationalizes objectives and goals.
3. Learning experiences ensure that students have the opportunity to meet objectives and goals.
4. Student evaluation methods ensure that students are evaluated in relation to goals and objectives.

Criterion 2. Students, during their participation in the nursing education program, demonstrate progress towards achieving professional practice requirements.

Indicators

1. Students meet established admission requirements which:
   (a) are congruent with the requirements of the Nurses (Registered) Act.
   (b) include prerequisites that provide reasonable assurance of success in the program.
2. Students meet established promotion requirements of the education institution.
3. Students achieve defined levels of performance in the program.

Criterion 3. Graduates of the program achieve professional practice requirements.

Indicators

1. Terminal evaluation of graduating students confirms that the students have met the goals and objectives of the program.
2. Graduate follow-up data from the employers indicates that the educational institution has prepared the graduates to meet requirements for professional practice as registered nurses.
3. Graduate follow-up data from the graduates indicates that the educational institution has prepared them to meet requirements for professional practice as registered nurses.
4. The graduates:
   (a) Pass the registration examination.
   (b) Meet registration requirements.

Registered Nurses Association of British Columbia. (1994). Education approval program: Information for basic and refresher nursing programs. Vancouver, BC: Author.

Appendix B

Approval of Schools of Nursing

Registered Nurses Association of British Columbia

Overview of the Approval Process

The approval process for a full review of a nursing education program is outlined in Section 9.7 of the Rules governing the approval of schools of nursing. The Education Approval Committee has the authority to make the process appropriate for the type of program being reviewed. For example, the review process can be modified for new and substantially altered programs, as well as refresher courses and programs being discontinued. An overview of the approval process for a full review is presented below.

Full Review Approval Process

Self-evaluation Report

A self-evaluation of the nursing education program in relation to the approval criteria is completed by the educational institution.

Preliminary Review

The Education Approval Committee reviews the self-evaluation report and instructs the site visitors.

Site Visit

A site visit team visits the educational institution and clarifies and validates data with program representatives. A report is made to the Education Approval Committee.

Formal Review

The Education Approval Committee reviews the reports, discusses tentative recommendations with the program representatives, and presents recommendations to the Board of Directors.

Decisions

The Board of Directors reviews recommendations and makes the final decision for approval.

Appeal

If decisions are questioned, the educational institution may request that the Board of Directors reconsider the decision.

Registered Nurses Association of British Columbia. (1994). Education approval program: Information for basic and refresher nursing education programs. Vancouver, BC: Author.

Appendix C

Approval of Schools of Nursing

Saskatchewan Registered Nurses Association

Overview of Approval Process

An overview of the approval process for a full review is presented below. Based on the circumstances of the program(changing, new, discontinuing), Council may determine that a full review process is not required.

Approval Process

Notification of Intent to Review Program

The Nursing Education Programs Approval Committee will notify the head of the nursing education program of the intent to review one year prior to the site visit.

Self-evaluation Report

A self-evaluation of the nursing education program in relation to the approval criteria and indicators is completed by the educational institution.

Review of Self-evaluation Report

The Nursing Education Programs Approval Committee reviews the self-evaluation report and instructs the assessment team.

Site Visit

An assessment team visits the educational institution(s) and clarifies and validates data with program representatives. A report is made to the Nursing Education Programs Approval Committee.

Review of Assessment Team's Report

The Nursing Education Programs Approval Committee reviews the report and prepares recommendations.

Recommendations to Council

The Nursing Education Programs Approval Committee presents recommendations to Council.

Decision and Notification to Program

The Council reviews recommendations and makes the final decision regarding approval. Council notifies the program in writing regarding its decision.

Submission of Annual Update

The Nursing Education Programs Approval Committee distributes an Annual Update form to the nursing education program to complete on an annual basis until the next review occurs.

Saskatchewan Registered Nurses Association. (1995). Approval of basic nursing education programs and nursing re-entry programs in Saskatchewan. Regina, SK: Author.

Accreditation of Nursing Education Programs in Canada

Wendy McBride, MA
The Canadian Association of University Schools of Nursing

Christa Bennett Dye, BScN, MHA, RN
The Canadian Association of University Schools of Nursing

Executive Summary

Key Stages in the Development of Accreditation Process

In 1942, eight university schools of nursing formed a national association (later called Canadian Association of University Schools of Nursing [CAUSN]).

In 1957, CAUSN established the *Desirable Standards for University Schools of Nursing* (revised in 1962), which provided a basic guide for developing university schools of nursing to follow on a voluntary basis. In addition, documents such as the *Guidelines for Baccalaureate Programs in Ontario* (ORCAUSN, 1970) and the *Criteria for University Schools of Nursing* (McGill University, 1971) were developed by other organizations on a regional basis.

At the 1971 National Conference on Assistance to the Physician, held under the auspices of the Department of National Health and Welfare, it was recommended that the accreditation of educational programs for health care professionals be treated separately from health services accreditation and that priority be given to educational accreditation.

In 1972, for the purpose of developing guidelines for nursing education at the baccalaureate level, the CAUSN Ad Hoc Committee on Evaluation submitted a report entitled *Tentative Statement for the Functions of the Baccalaureate Nurse - Evaluation of Baccalaureate Schools of Nursing*.

In 1972, CAUSN was officially recognized by Canadian university schools of nursing and the nursing profession as the national agency responsible for accreditation. CAUSN formed a committee in order to "promote activities on evaluation and any developments towards accreditation".

The initial process of accreditation was based on the four key criteria proposed by Allen (1977) and adapted by CAUSN: relevance, accountability, relatedness, and uniqueness. Behavioral indicators were identified for each of the four criteria and raw scores were obtained for each indicator. Three methods of data collection were used to establish a rating for the educational program: self-evaluation report, nursing education data base, and on-site visits.

By 1987, the full accreditation program had been developed, tested in a number of schools and formally applied.

In December 1993, the CAUSN Council approved two major changes: a reduction in the number of indicators and the removal of the numerical weighting system.

Summary of Current Status of Accreditation Process

There are five major components to the current CAUSN accreditation process:

- the university program submits a request for an accreditation review to the Board of Accreditation;
- the program prepares and submits the Self-Study Report to the Secretary, Board of Accreditation;
- a site visit is conducted and a report completed by the appointed review team;
- the Board of Accreditation reviews the report, decides on the accreditation status to be awarded and transmits this information; and
- the program accepts or appeals the decision of the Board.

As of March 1996, 14 of the 32 member schools/faculties of nursing in Canada have been accredited, and two have the status of candidacy. Decisions on accreditation for one more member and on candidacy for one member plus four collaborative partners will be made in May 1996. An additional 14 programs are scheduled for accreditation review, including the two presently under candidacy status and ten programs scheduled for re-accreditation.

The CAUSN accreditation program has recently undergone a review, with the monograph revisions completed in early 1995. As a result, no major modifications are presently under review. Once the revised program has been utilized for accreditation reviews, it will be easier to determine if any additional changes will be required. The accreditation process is naturally expected to change in the future, as the educational system changes.

It now appears that some benefit could be derived from an effort to educate the schools/faculties on the flexible nature of the criteria, the rationale behind the indicators and the purpose of the review team. A better understanding of the ultimate goal of accreditation (i.e., quality assurance in nursing education) would probably encourage more member institutions to voluntarily participate in the process in order to remain current with peer institutions and to continually strive toward excellence.

Projections for Accreditation Process over Next Ten Years

As provinces look for ways to reduce the time and expense devoted to the approval process, accreditation could be selected as a suitable replacement. This course of action could be strengthened by a public demand for protection and an increased interest in assuring the relevancy of programs.

The alternative perspective is that accreditation may not be favored by governments within the next ten years. Both the federal and provincial levels of government are placing an increased emphasis on ensuring that graduates acquire job-specific skills. It is possible that governments will want increased control over the universities in order to regulate the teaching of these job-specific skills. In light of this, governments may seek to decrease the autonomy of universities and the external accrediting agencies.

Accreditation is presently very well regarded and highly valued by many universities and professional organizations. It is predicted that this level of university support for accreditation will remain strong over the next ten years and may even increase. It is also expected that universities will be willing to support recommended program changes which are suggested as a result of the review process.

In the future, it is expected that throughout Canada there will be strong support for accreditation from the university schools/faculties of nursing. A number of reasons for undertaking accreditation have been put forth by the schools/faculties of nursing:

- status or prestige;
- reaffirmation of the quality of the program;
- a desire to make known the quality of the program;
- the opportunity for peer support and feedback;
- outside support for the acquisition of required resources; and
- a commitment to the process of accreditation (Pearce, 1995).

These reasons are likely to remain constant and will assist in enhancing support for accreditation.

History of the Accreditation Process

Background to the Establishment of the Accreditation Process

Key Factors and Key Organizations

A number of concurrent events contributed to the establishment of a Canadian program of accreditation for university schools of nursing. These events occurred on both the macro level of national health services education accreditation and on the micro level of nursing accreditation.

In 1942, the eight existing university schools of nursing formed a national association which would later be entitled the Canadian Association of University Schools of Nursing (CAUSN). In 1957, CAUSN established the

Desirable Standards for University Schools of Nursing (revised 1962) which provided a basic guide for developing university schools of nursing to follow on a voluntary basis. In addition, documents such as the *Guidelines for Baccalaureate Programs in Ontario* (ORCAUSN, 1970) and the *Criteria for University Schools of Nursing* (McGill University, 1971) were developed by other organizations on a regional basis.

At the 1971 National Conference on Assistance to the Physician, held under the auspices of the Department of National Health and Welfare, accreditation was identified as a possible means of regulating human resources within the health care system. As a result, the Health Programs Protection Branch established a working group to examine accreditation. The working group recommended that the accreditation of educational programs for health care professionals be treated separately from health services accreditation and that priority be given to educational accreditation (CAUSN, 1984).

At this time, the need for a national approach to evaluation was recognized and CAUSN established an Ad Hoc Committee on Evaluation for the purpose of developing guidelines for nursing education at the baccalaureate level. In 1972, the ad hoc committee submitted a report entitled *Tentative Statement for the Functions of the Baccalaureate Nurse - Evaluation of Baccalaureate Schools of Nursing*. This document contained a statement of the critical functions of a baccalaureate nurse and a statement identifying relevance, accountability, relatedness and uniqueness as the four criteria for the evaluation of schools of nursing (CAUSN, 1984).

Date of Establishment of Accreditation Process

Founding Organizations

In 1972, CAUSN was officially recognized as the national agency responsible for the accreditation of Canadian university schools of nursing by Canadian university schools of nursing and the nursing profession. As a result, the CAUSN Committee on Accreditation was formed in order to "promote activities on evaluation and any developments towards accreditation" (CAUSN, 1984). The committee formally began work in 1974 and focused primarily on the overall structure of accreditation activities and the implications for CAUSN. The committee was also responsible for examining the administration and financing of the accreditation program as well as determining the benefits for the schools of nursing (CAUSN, 1984).

Stated Objectives

CAUSN recognized the importance of evaluating educational programs and accepted accreditation as an effective method of raising standards. The initial objective of accreditation was to facilitate the development of university nursing education according to national goals. These national goals included the development of relevant educational programs at both the undergraduate and graduate level; the development of a scholarship base in nursing; and the development of exemplary nursing services in which students would learn to nurse and faculty would be able to practice and study nursing (CAUSN, 1984). The aim of accreditation was to promote the interests of both the public and the nursing student through the improvement of education and the portability of educational qualifications. Finally, accreditation was to be conducted with minimal time, effort and cost (CAUSN, 1984).

Key Features

As a non-governmental organization, CAUSN chose to carry out the accreditation process on a voluntary basis and at the national level. In developing the process, a number of key assumptions were made:

- Nursing as a profession is accountable to the public and has a responsibility to ensure the quality of the educational preparation of its members;
- Nursing has the major responsibility for establishing, developing and monitoring standards for educational programs in nursing;
- Essential qualities having attributes of change and development can be identified;
- The qualities or criteria (relevance, accountability, relatedness and uniqueness) are amenable to measurement; and
- Standards can be developed that will promote change, innovation, and diversity within and among programs, as well as responsiveness to societal needs both now and in the future (CAUSN, 1984).

Initial Structure of Accreditation Process

Key Organizations and Levels of Authority and Control

In 1984, the CAUSN Council approved the establishment of a Board of Accreditation for the purpose of administering the accreditation program and establishing a list of qualified nurse educators to serve as review team members. In order to ensure impartiality in the granting of accreditation status, the Board of Accreditation would

function independently of the CAUSN Council. The Committee on Accreditation, which played a key role in the development of the accreditation process and criteria, was retained for the purpose of conducting periodic evaluations of the program and making policy recommendations (CAUSN, 1984).

Outline of Initial Process

Steps/Stages of Process

The initial process of accreditation was based on the four key criteria proposed by Allen (1977) and adapted by CAUSN:

- Relevance - the extent to which the mission and goals of a program reflect a response to the major trends in society that impact on the health needs, present and future, of the larger community;
- Accountability - the extent to which the program teaches the student that the primary responsibility in nursing is to the client, that is community, group, family, person;
- Relatedness - the extent to which the components of a program support and build on other parts, thereby promoting or negating the achievement of goals. The components are 1) curriculum, 2) the teaching of nursing, 3) research, clinical practice, and professional activities, and 4) administration. This criterion is a measure of internal consistency.
- Uniqueness - the extent to which a program capitalizes on unique characteristics of its resources (faculty, community values, financial support) within its particular setting (CAUSN, 1995).

Behavioral indicators were identified for each of the four criteria. Raw scores from one (low) to four (high) were obtained for each indicator, which permitted the calculation of national means by which to establish the standards. At the outset of the accreditation process, the criteria of relevance, accountability and relatedness all required a minimum score of three, while a score of two was required for uniqueness (CAUSN, 1986).

The three methods of data collection used to establish a rating for the educational program were:

Self-Evaluation Report
This was comprised of a questionnaire designed to evaluate the four criteria. The school seeking accreditation was required to numerically rate the program on each of the 75 indicators, give examples to support the rating and provide a summary of the information related to each individual criterion.

Nursing Education Data Base
This tool, completed by the school seeking accreditation, required factual information relating to the development of the program, administration, the faculty, the students, curriculum, learning resources, and graduates.

On-Site Visits
The on-site visit was designed to be carried out by three external review team members, nominated from the faculty and administration of CAUSN member institutions, who would collect data and submit a report of their findings to the Board of Accreditation (CAUSN, 1986).

The material submitted by both the school and the review team would be reviewed by the Board of Accreditation with the Dean/Director of the school present. Based on their findings, the Board could choose to grant the status of full accreditation for a seven-year period, grant conditional accreditation for not more than three years or deny accreditation (CAUSN, 1986).

Major Changes in Process Over Time

Nature of Changes and Reasons for Modifications

Over time, a number of significant revisions have been made to the accreditation process. In December 1993, the CAUSN Council approved two major changes: a reduction in the number of indicators and the removal of the numerical weighting system.

Under the initial process, the criterion of Relevance had eight indicators, Accountability had 18 indicators, Relatedness had a total of 45 indicators for its four subcomponents of curriculum, teaching of nursing, research and administration and the final criteria of Uniqueness had four indicators for a grand total of 75 indicators on which to evaluate the program. As a result, the self-study was a costly and very labor-intensive task. This process was streamlined through the removal of a number of redundancies which resulted in the number of indicators being reduced substantially to 40 items.

The second major change was the removal of the numerical weighting system which was used to "score" the program on each of the indicators. This was to prevent schools/faculties from focusing on and disputing the assignment of individual numerical scores while missing the global perspective of the criteria.

In addition to these changes, the monograph underwent revisions, which were approved in December 1994. During these revisions, certain sections were rewritten and

combined in order to avoid overlaps, improve consistency and provide flexibility for the wide variety of programs now available (e.g., generic, post-RN and collaborative). The CAUSN statement on Baccalaureate Education was inserted in the monograph and the policies and procedures were reorganized and updated (CAUSN, 1994). These changes assisted in streamlining the accreditation process and facilitating the use of the monograph by organizational units seeking accreditation.

Finally, in December 1994, the CAUSN Council voted to eliminate the Committee on Accreditation, which had previously been responsible for three activities: monitoring, and evaluating the accreditation process; developing of policies for consideration by Council; and responding to specific requests from Council pertaining to accreditation (CAUSN, Bylaws). Since the Committee on Accreditation was originally established to design the accreditation policies and procedures and oversee the implementation of the program, it was decided that it had fulfilled its role. Any remaining duties were delegated to the Executive Committee through the President-Elect.

Current Status of Accreditation Process

Description of Current Accreditation Process

Steps/Stages of Process

There are five major components to the current CAUSN accreditation process:

- the university program submits a request for an accreditation review to the Board of Accreditation;
- the program prepares and submits the Self-Study Report to the Secretariat, Board of Accreditation;
- a site-visit is conducted and a report completed by the appointed Review Team, drawn from a pool of experienced faculty and administrators in CAUSN member schools;
- the Board of Accreditation reviews the report, decides on the accreditation status to be awarded and transmits this information; and
- the program accepts or appeals the decision of the Board.

Each of these steps will be discussed in greater detail.

Request for Accreditation

In order to initiate the accreditation process, a program must submit an application for accreditation to the Board of Accreditation. To be eligible, the school/faculty must have graduated at least one class from the particular program for which accreditation is sought. This includes programs undergoing major curriculum revisions. Programs not eligible for accreditation may apply for candidacy, an option available to new programs in the early developmental stage. Candidacy status requires the program to adhere to CAUSN's educational policy (CAUSN, 1995).

Program Preparation

Once the application for accreditation has been accepted, it is the responsibility of the program to prepare for the on-site visit. This requires the completion of an extensive Self-Study Report. While the organizational units will vary in their approach to the completion of this report, the process includes giving examples and summarizing pertinent information within the context of three separate documents:

- The Nursing Education Data Base, which requires a description of the nursing program and its environment, the university, and the community served by the program. Factual information must be provided on the development of the program, administration, the faculty, the students, curriculum and learning resources, and graduates.
- The Self-Evaluation Questionnaire, which requires the organizational unit to evaluate its program based on each of the four criteria and their indicators.
- The Program Synopsis, which incorporates an overall summary of the program and a description of the self study process.
- These three completed documents must be submitted to the Executive Director of CAUSN prior to the on-site visit.

Site Visit

Once a program has been accepted for an accreditation review, the Board of Accreditation is responsible for selecting a Review Team of three members to conduct an on-site visit. The organization undergoing the review is given the opportunity to request a change of Review Team members and is consulted in selecting the on-site visit date. Prior to the on-site visit, the Review Team receives a copy of the program's Self-Study Report.

The main purpose of the on-site visit is to collect data through observation and interview in order to (1) validate, clarify, and supplement the information which is contained in the Self-Study Report; and (2) provide the Board of Accreditation with a report which both describes the program and assesses it against the criteria (CAUSN, 1995).

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At the completion of the on-site visit, the Review Team provides the head of the school/faculty with a verbal report that outlines the strengths of the program and indicates any areas which require further development. A written report summarizing the findings of the on-site visit and any differences of opinion is submitted to the Board of Accreditation by the Review Team. A standard format has been developed for this submission. A copy of this report is also forwarded to the organizational unit for an examination of the accuracy of the factual information.

Decision on accreditation status

The report is reviewed at a meeting of the Board of Accreditation with the Dean/Director of the organizational unit under review present for part of the discussion. Based on the information received, the Board will select one of three accreditation options: (1) to grant full accreditation status for a seven-year period; (2) to grant accreditation for a three-year period with specific recommendations which address identified concerns; and (3) to deny accreditation. The decision of the Board, with supporting rationale, is communicated in writing to the Executive Director of the organizational unit, to the President of CAUSN, and to the Review Team members (CAUSN, 1995).

Appeal process

The decision of the Board of Accreditation is final and may only be appealed when the organizational unit alleges that the Board failed to observe the procedures for accreditation as approved by the Association. Under this circumstance, the organizational unit must appeal to the CAUSN Executive Committee within 30 days of the Board's report. Following this, a three-member Appeal Committee will be established in order to investigate the allegations and reach a decision. The Appeal Committee will remand the case to the Board of Accreditation only if it is determined that the Board failed to observe the proper accreditation procedures. In such situations, the Board of Accreditation will re-examine the case in accordance with the recommendations of the Appeal Committee (CAUSN, 1995). After the resolution of the appeal is complete, the final accreditation status of the program/faculty will be disseminated to the appropriate individuals.

Monitoring and Evaluation Mechanisms

The Board of Accreditation may review the status of an accredited program if it receives a written complaint indicating the standards have been violated, or upon request from the organizational unit when major changes have occurred that affect the standards. If it is determined that a review is required, the Board of Accreditation will request documentation relating directly to the reason for review. A site visit will be conducted (CAUSN, 1995).

Upon completion of the review, the Board will decide whether the standards are being observed and whether a violation is of a sufficiently serious nature to revoke the status of accreditation. The decision of the Board is communicated to the organizational unit, which has the right to appeal in accordance with the regular appeal process.

Strengths and Weaknesses of Current Accreditation Process

Perceived Strengths of Process

The current accreditation process is perceived to have a number of strengths. These strengths can be divided into three main categories: the criteria; the self-evaluation tool; and relationships.

The strength of the criteria lies in the fact that they are broad and flexible, thus increasing their applicability to the different nursing programs. The criteria and the accreditation process as a whole have a developmental focus (S. French, personal communication, 1995).

The self-evaluation process is another strength within the CAUSN accreditation program. The schools/faculties which go through the self-evaluation process report that on its own it is an excellent learning tool. By completing the self-evaluation, the schools/faculties are able to gain a better understanding of their program in terms of its strengths, weaknesses and directions for change (B. Thomas, personal communication, 1995). Many programs are currently undergoing curriculum revisions, and the completed accreditation self-evaluation form and the review team recommendations are frequently considered, or used, to support the revisions (J. Pearce, personal communication, 1995). This indicates that programs are using the accreditation process and the interim period as an opportunity to promote dynamic change.

It has also been reported that the accreditation process promotes and strengthens relationships between the faculty and students. This process helps draw the members of the program together as they prepare for the on-site visit (J. Pearce, personal communication, 1995). Additionally, accreditation is a process that is well understood by nursing colleagues in the hospital sector. They, too, offer their support during the accreditation process and recognize the prestige of the award (B. Thomas, personal communication, 1995).

Perceived Weaknesses of Process

Unfortunately, there are certain areas within the accreditation process that may require strengthening or ongoing monitoring. The process is onerous and demanding in terms of both financial and non-financial costs. Schools/faculties incur financial costs with respect to the preparation of the self-study document, the fees paid to CAUSN and the expenses of the review team members. Non-financial expenses include the amount of time required on the part of the faculty and the support staff in preparing for and undergoing the on-site visit (B. Thomas, personal communication, 1995).

Another identified weakness is the small pool of individuals who truly understand the criteria and their meaning. A related issue is that the indicators have a subjective element that cannot be fully reduced to an objective measure. This lack of rigor may lead to an uneasiness among those individuals who do not fully understand the criteria (S. French, personal communication, 1995).

Finally, it appears that some schools/faculties do not fully understand the role of the Board of Accreditation and the purpose of the review team. This weakness has become apparent through requests from schools/faculties that the Board receive all the raw data rather than only the review team report (S. French, personal communication, 1995).

Proposed Modifications to Current Process

The CAUSN accreditation program has recently undergone a review with the monograph revisions having been completed in early 1995. As a result, no major modifications are presently under review. Once the revised program has been utilized for accreditation reviews, it will be easier to determine if any additional changes will be required. The accreditation process is naturally expected to change in the future, as the educational system changes.

It now appears that some benefit could be derived from an effort to educate the schools/faculties on the flexible nature of the criteria, the rationale behind the indicators and the purpose of the review team.

Impact of Accreditation Process

Incentives for Undertaking Accreditation Process

The major incentive for undertaking accreditation has been identified as the opportunity to critically examine the program and receive external peer feedback and recommendations. It is also perceived as an opportunity to gain recognition and prestige and may provide the necessary external support for obtaining resources.

Number of University Schools/Faculties Potentially Affected

As of March 1996, there will be 37 university schools/faculties of nursing in Canada, of which 32 will be members of CAUSN. Four of the non-member schools/faculties are very small schools, which are part of the Université du Québec system. They have expressed interest in joining CAUSN as a group pending the availability of funding. The fifth school is also interested in joining CAUSN.

Number of University Schools/Faculties Accredited

As of March 1996, 14 of the 32 member schools/faculties of nursing in Canada will have been accredited, and two have the status of candidacy. Decisions on accreditation for one more member and on candidacy for one member plus four collaborative partners will be made in May 1996. An additional 14 programs are scheduled for accreditation review, including the two presently under candidacy status and 10 programs scheduled for re-accreditation.

Number of University Schools/Faculties Not Accredited

Presently, eight member nursing programs in Canada are not accredited and not presently listed for accreditation or candidacy review. All but one of these programs are planning to undergo accreditation in the future. The school/faculty not planning accreditation cited financial resources as the deterrent (J. Pearce, personal communication, 1995).

Implications for Non-Accreditation

Since accreditation is a voluntary process, it is undertaken at the discretion of the school/faculty. Clearly, there is no intention to "punish" those organizations that do not choose to seek accreditation. Some non-accredited schools have, however, voiced the concern that as more programs become accredited, they may be "conspicuous by their absence". Thus, non-accredited programs are questioning whether they truly have a choice of options (J. Pearce, personal communication, 1995).

Projections for Accreditation Process Over the Next Ten Years

Status of Accreditation Process

Recognition by Government

It is difficult to determine with any certainty the federal and provincial governments' level of interest in accreditation and the manner in which it will be expressed over the next ten years. There are circumstances that would indicate an increase in governmental support and, alternatively, circumstances which indicate that accreditation may not be of interest in the future.

In Canada, some provincial governments support accreditation as an alternative to, or in place of, the approval process. Under this scenario, accredited programs automatically become approved and are not required to undergo the provincial approval process. This naturally results in significant savings in terms of time, money and duplication of effort on the part of the university. As provinces also look for ways to reduce the time and expense devoted to the approval process, accreditation could be selected as a suitable replacement (J. Pearce, personal communication, 1995). This course of action could be strengthened by a public demand for protection and an increased interest in assuring the relevancy of programs (S. French, personal communication, 1995).

The alternative perspective is that accreditation may not be favoured by governments within the next ten years. Both levels of government are placing an increased emphasis on ensuring that graduates acquire job-specific skills. It is possible that governments will want increased control over the universities in order to regulate the teachings of these job-specific skills. In light of this, governments may seek to decrease the autonomy of universities and the external accrediting agencies would be perceived as having too much control (S. French, personal communication, 1995).

Support from Universities

Accreditation is presently very well regarded and highly valued by many universities and professional organizations. It is predicted that this level of university support for accreditation will remain strong over the next ten years and may even increase (B. Thomas, personal communication, 1995). Many universities do not wish to "jeopardize" the status of their accreditation programs and are willing to provide support where necessary (S. French, personal communication, 1995). It is also expected that universities will be willing to support recommended program changes which are suggested as a result of the review process (B. Thomas, personal communication, 1995). Schools/faculties reported that their universities were very prompt to acknowledge, in a positive manner, the granting of accreditation status (J. Pearce, personal communication, 1995). Despite this great interest on the part of the universities, it must be recognized that all support will be affected by the availability of financial resources (S. French, & J. Pearce, personal communication, 1995).

Support from Schools/Faculties

Throughout Canada, strong support is expected for accreditation from the university schools/faculties of nursing, especially with increased recognition of its benefits and its non-punitive character (S. French, personal communication, 1995). This predicted increase is supported by the number of schools seeking or planning to seek accreditation.

A number of reasons for undertaking accreditation have been identified by the schools/faculties of nursing. These reasons were similar for both accredited and non-accredited programs and include:

- status or prestige;
- reaffirmation of the quality of the program;
- a desire to make known the quality of the program;
- the opportunity for peer support and feedback;
- outside support for the acquisition of required resources;
- perception of accreditation as a good use of resources; and
- a commitment to the process of accreditation (J. Pearce, personal communication, 1995).

These reasons are likely to remain constant and will assist in enhancing support for accreditation.

Proposed Modifications to the Current Process

Proposed Changes and Reasons

As indicated, the Canadian accreditation program has recently completed a three-year review and revision; however, it is still realistic to expect changes over the next ten-year period. It is predicted that the four broad criteria will remain the same in the future; however, it is expected that the indicators will be refined and modified as society and nursing change (S. French, personal communication, 1995). It is felt that the current criteria are flexible enough to incorporate necessary changes in their individual indicators over time.

Questions have also arisen about a possible "pendulum effect" with respect to the use of a numerical weight-

ing system. The weightings were removed in the last set of revisions; however, their suitability for re-implementation may be examined (B. Thomas, personal communication, 1995). At present, review team members are required to be faculty members in a nursing program at the university level. In the future, changes may require that review team members themselves come from an accredited program (B. Thomas, personal communication, 1995).

A number of other potential modifications have been suggested as future directions are examined. Specifically, as the government focuses on ensuring the acquisition of job skills, there may be a greater focus on technical skills over analytical skills, along with an increased demand for specialized undergraduate accreditation. The implementation of collaborative programs among universities and colleges should not require, but may produce, a change in the interpretation of the criteria. Finally, indicators suggest that an accreditation program for graduate programs will be in the late developmental or early implementation stage within the next five to ten years (S. French, personal communication, 1995).

Anticipated Expansion/Deletion of Accreditation Process

Proposed Changes and Reasons

Expansion of the accreditation process is anticipated over the next ten years, provided the Board of Accreditation remains strong and is perceived to be credible and have good decision-making abilities. It will also be necessary to foster the quality of the review team members and ensure they are seen as skilled (B. Thomas, personal communication, 1995). Accreditation is perceived to give the school/faculty of nursing prestige and this benefit also will contribute to the expansion of the process (B. Thomas, personal communication, 1995).

Expansion of accreditation could be expected as the public pressure for quality educational programs increases. Accreditation may be seen as a mechanism through which to ensure this quality and remain competitive, as well as a means of ensuring greater accountability in this time of limited resources.

Nationally, the Canadian accreditation program could expand within the country as Canadian universities fight for international recognition and status. Accreditation should represent excellence to other countries and may be a drawing point for Canada when competing for international students.

The possibility of deletion of the accreditation process cannot be completely eliminated in light of the North American Free Trade Agreement (NAFTA). The United States' National League for Nursing (NLN) has a very well developed and widely accepted accreditation process. In order to ensure greater accessibility to programs, pressure may be exerted on CAUSN to conform with the US standards through adoption of the NLN system (S. French, personal communication, 1995). On the other hand, the Canadian accreditation process is streamlined, coherent and flexible, all qualities which support adoption of the Canadian model .

Looking specifically to Canada, two factors could negatively affect the future of the accreditation program. First, if schools/faculties of nursing perceive the standards to be excessively stringent, they may be unwilling to undertake the process (B. Thomas, personal communication, 1995). Secondly, the Canadian university professorate is aging and many will retire within the next ten years. There is a concern that the new generation of professors may not be as committed to accreditation, since they did not participate in the early developmental stages of the process. These individuals may be unaware of the rationale behind the process and may not value the program. In addition, the present review team members may tend to be more senior faculty members; the younger generation would be unfamiliar and inexperienced in this area. The establishment of a pool of experienced, qualified review team members will not be facilitated by the university trend toward increased hiring on a part-time basis (J. Pearce, personal communication, 1995).

International Interest in Accreditation

Level of Interest in International Arena

The international level of interest in accreditation is likely to increase in the future. As the CAUSN accreditation program is more widely communicated through international publications and conferences, other countries will realize that alternatives exist to the well-known NLN process. This may result in increased requests for information from South American countries, the Caribbean and the Commonwealth countries. Requests may also start to appear from the Middle Eastern countries where Canadian nursing is well recognized. The key to increasing the level of international interest in the Canadian accreditation process lies in the establishment and development of linkages between the nursing educational systems in Canada and abroad (S. French, personal communication, 1995).

Types of Requests for Information or Consultation

International requests pertaining to accreditation currently relate to both information and consultation. In the

future, countries will be looking for consultations that will assist in increasing the quality of their nursing education programs. More requests will be made for approaches and tools to be used in program evaluation.

Information requests will likely pertain to requests for assistance with the establishment of foreign accreditation programs. Since the CAUSN accreditation program is based on a clear, coherent and flexible process, it may prove suitable on an international basis. In addition, the four criteria, especially uniqueness, are general, prescriptive criteria with an element of flexibility that could prove applicable on an international level (B. Thomas, personal communication, 1995). Despite this, international requests will likely focus on process information to assist in the development of their own programs (S. French, personal communication 1995). Canada will be able to provide other countries with guidance in establishing their own programs without necessarily replicating the whole Canadian program (B. Thomas & S. French, personal communication, 1995).

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Approval and Accreditation of Nursing Education Programs in Mexico

Lic. Sara Alicia Ponce de León Muñoz
Colegio Nacional de Enfermeras, A.C.

Ma. del Carmen Arancón García
Colegio Nacional de Enfermeras, A.C.

Enf. M.A.B. Leticia Moriel Corral
Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería

Executive Summary

Key Stages in the Development of Approval Processes

The general education system of Mexico has influenced the development of professional nursing in this country. The education system, in turn, has been influenced by the social and political development of Mexico.

From the time the first nursing school was created in Mexico early in the 20th century, the curricula have been systematically approved by each individual nursing school. This activity became subject to regulation through the 1917 Political Constitution of the Mexican United States. Article 3 of the Constitution details the characteristics of education in Mexico. This Article was the foundation for the approval systems set up by the Education Ministry of Mexico (Ministerio de Educación de México) known as the Public Education Secretariat (Secretaría de Educación Pública, or SEP), the universities and the higher education institutes of Mexico.

Based on the established guidelines, each nursing school conducts its own curriculum planning process. This process first takes place in work groups with representatives from the school community and health professionals. The work of these groups is then approved by a Technical Council consisting of representatives from the faculty and the student community. Finally, the highest academic authorities of each higher education institution approve the curriculum and its implementation.

Key Stages in the Development of the Accreditation Process

There is no accreditation system as such in Mexico nor is there a non-governmental agency in charge of periodically and systematically assessing higher education institutions in general and/or nursing schools in particular. Teaching practices, research, cultural extension, and compliance with desirable quality standards established by an independent body are not systematically evaluated by non-governmental agencies independent from the schools.

Accreditation must be conducted through, and as a result of, an assessment and follow-up process. This follow-up process is a basic stage for the creation of a future accreditation system. Since the 1970's, educational assessment has been strongly promoted at the national level. Both the SEP and the National Association of Universities and Higher Education Institutes (Asociación Nacional de Universidades e Instituciones de Educación Superior, or ANUIES), a government entity, have pro-

moted actions aimed at achieving higher educational quality levels. Such actions include the creation of a systematized assessment process, which includes the assessment of curricula. As part of this process, the National Higher Education Assessment Commission (Comisión Nacional de la Evaluación de la Educación Superior) was created in 1989. The nursing profession participates in this Commission.

Summary of the Current Status of Approval Processes

Some standards, criteria and regulations have been established in higher education institutions. These are applied at the nursing schools in order to determine the approval of curricula and the functioning requirements of the schools.

The approval process consists of two stages: an academic approach and a legal and administrative approach. The academic stage begins at the school with the approval of the curriculum by the Teachers' Academy (Academia de Maestros). It is then approved by the School Technical Advisory Council (Consejo Téchnica Consultivo Escolar) and is sent to the Councils on Plans and Programs (Consejos de Planes y Programas) of the central academic area of the relevant educational institution for final approval. Once this stage is approved, a legal process is initiated with the General Professions Directorate (Dirección General de Profesiones, or DGP) of the SEP in order to obtain legal registration from the government.

Summary of the Current Status of the Accreditation Process

Recently, a foundation has been laid for the creation of assessment and follow-up processes in order to obtain feedback on the quality of education, research and cultural extension. Such activities have been intensified at the nursing schools in view of the encouragement of accreditation processes by the globalization of nursing and the North American Free Trade Agreement (NAFTA). Planning activities have intensified in particular by the participation of the National College of Nurses (Colegio Nacional de Enfermeras, A.C., or CNE) and the National Federation of Associations of Nursing Schools (Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería, or FENAFEE) in the Trilateral Initiative for North American Nursing.

Ten-Year Projections for Approval Processes

- Analysis of the standards applied in the approval process of educational programs.
- Comparative study of the profession's regulatory standards.
- Increased participation in the drafting of professional curricula as established by the Law on Professions for the Colleges of Professionals (Colegios de Profesionistas).

Ten-Year Projections for the Accreditation Process

This process is expected to be conducted in stages. An analysis will be made of the feasibility of developing the accreditation process in accordance with the school levels, beginning with the first level (Bachelor in Nursing). The following activities are considered to be necessary for this process:

- Consolidation of the Approval and Accreditation groups.
- Drafting of standards for approval and accreditation with the participation of nurses working in health services, nursing schools, State Nursing Colleges (Colegios Estatales de Enfermería), Regional School Associations (Asociaciones de Escuelas Regionales) and FENAFEE.
- Dissemination of information on these processes to health and education institutions and organizations and promotion of their support for the activities to be conducted during the planning and implementation stages.

History of Approval Processes

Background to Establishment of Approval Processes

Key Factors and Organizations

The establishment of health care institutions (the first hospital opened in 1524) required staff to provide nursing care in hospitals, in health centers and to the population in general through community work. Personnel that filled these roles had minimal training.

As progress was made in science, health-related knowledge and educational development, as awareness developed of social and economic needs, and as politics evolved, the need emerged for formal university education. This need was met by the creation of the National

School of Nursing at the National Autonomous University of Mexico (Escuela Nacional de Enfermería de la Universidad Nacional Autónoma de México) during the first decade of this century.

The development of legal standards in Mexico has provided the foundation for nursing standards, from nursing's creation as an activity requiring no formal training to its current professional status. The 1814 Constitutional Act indicated that the Supreme Congress should approve regulations for health care. Subsequently, the 1857 Constitution applied the federalism principle by granting the States power to legislate on health issues. The current Political Constitution of Mexico, first issued in 1917, grants the Congress the power to pass laws on health. In 1983, health was included as a constitutional right and codified in a specific law including the legal standards expressed by the Constitution. In terms of education, which is also a constitutional right, the Constitution includes general standards for education, specific laws for various educational levels (General Education Law) and laws referring to higher education (General Law on Professions). The General Education Law provides for the prerequisites and characteristics of technical and higher levels of education, while the General Law on Professions includes provisions for the bachelor's degree, specialty studies, master's and doctoral degrees.

The General Law on Professions, issued in 1945 and updated in the 1970's, identifies the professions requiring a degree and a license, which include the nursing profession and midwifery. The license (Cédula Profesional) is a formal registration to practice a profession. The 1945 Law also included standards, objectives and participation areas for the Colleges of Professionals. These standards remain in force.

Professional groups, organized by disciplines and with the participation of representatives from the SEP's General Professions Directorate, created a forum with legal power for nurses to influence professional practice and education.

Establishment of Approval Processes

Approval processes were established with the creation of the first nursing school, which was required to submit its curriculum to the university and comply with the requirements set by the university for all professions. Subsequently, all public schools of the universities and higher education institutes were required to have their curricula approved, first by the School Councils and then by the General Council or the University Board of Directors of the relevant institution in each state. Private schools had to comply with the requirements set by the officially recognized educational institution to which they were incorporated.

This is a compulsory system with general standards set by law and applied at a national level. There are also standards for each state. The government regulates the standards at both the national and state levels. Each educational institution has its own regulations and it is at this level that the profession intervenes.

Initial Structure of Approval Processes

The key organizations involved in approval processes are the SEP, the Higher Education Institutes (Instituciones de Educación Superior), the Colleges of Professionals (Colegios de Profesionistas) and the School Associations (Asociaciones Escolares). The levels of authority and control are determined by legislation that charges the SEP and the Higher Education Institutions (Institutos de Educación Superior) with approving and validating the curricula and educational programs. The Colleges of Professionals (Colegios de Profesionistas) and the School Associations (Asociaciones Escolares) may also intervene.

Main Changes in Approval Processes Over Time

Progress in scientific, social, political and professional spheres has enriched each stage of the development of approval processes and also has served as a foundation for change. Increasing numbers of well-prepared nurses have participated in the training of nurses and have taken responsibility for drafting proposed curricula and educational programs. Likewise, the Colleges of Professionals (Colegios de Profesionistas) have increased and, in each state of the Mexican Republic, have contributed to the drafting of curricula and educational programs, as well as to the development of approval processes.

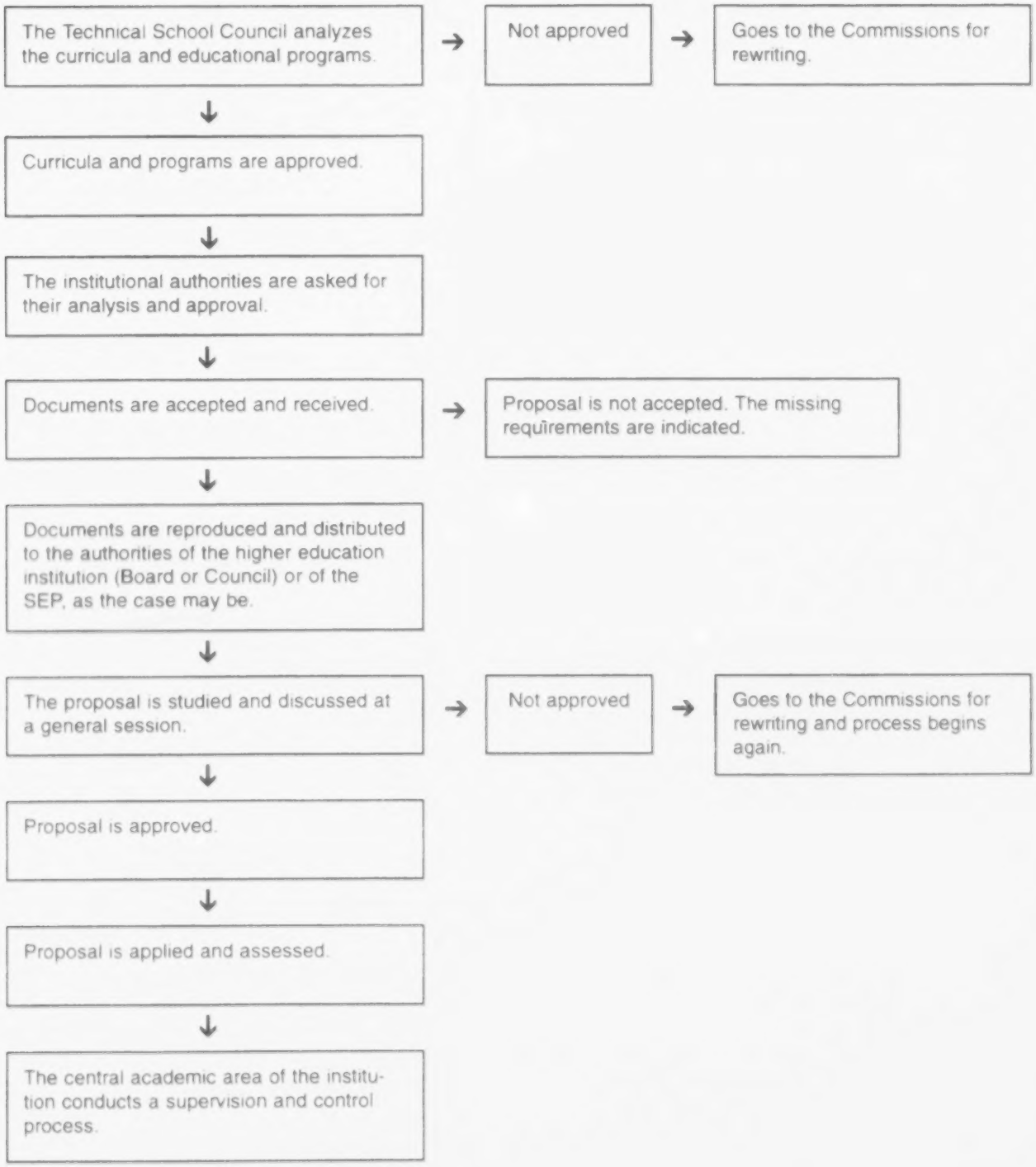
Current Status of Approval Processes

Detailed Description of the Approval Processes

Once the curricula and educational programs have been drafted with the participation of the school community and the nursing staff, the steps outlined in the following Approval Process Flow Chart take place:

(See chart on next page)

APPROVAL PROCESS FLOW CHART


The Technical School Council analyzes the curricula and educational programs.
Not approved
Goes to the Commissions for rewriting.
Curricula and programs are approved.
The institutional authorities are asked for their analysis and approval.
Documents are accepted and received.
Proposal is not accepted. The missing requirements are indicated.
Documents are reproduced and distributed to the authorities of the higher education institution (Board or Council) or of the SEP, as the case may be.
The proposal is studied and discussed at a general session.
Not approved
Goes to the Commissions for rewriting and process begins again.
Proposal is approved.
Proposal is applied and assessed.
The central academic area of the institution conducts a supervision and control process.

Strengths and Weaknesses of Current Approval Processes

The strengths of the current processes are that they are systematic, well defined, include an assessment and follow-up, and are determined by laws and academic standards. They have been strengthened by the increased involvement of nurses. Also significant is the degree of intervention of the Colleges of Professionals (Colegios de Profesionistas) in each state and the cohesion and consensus functions performed by the National College of Nurses (Colegio Nacional de Enfermeras, A.C.).

One weakness is that nurses do not have full participation and decision-making power in all stages of the process in every state. In addition, there are no approval councils formed by nurses to approve curricula and educational programs.

Impact of Approval Processes

Approval processes have been created. Incentives to increase their quality include:

- the need to participate with increased levels of authority, power and decision-making as a means to provide better health care;
- the need to participate in policies that grant increased importance to primary care;
- increased control over education that favors the professional level; and
- equal participation with other professions in practice, work conditions and development opportunities.

Impact on Schools

- The number of nursing schools affected by approval processes is approximately 253.
- The number of schools approved is 234.
- The number of schools not approved is 19.

(Source: Directory of Nursing Schools, 1993.)

Implications of Non-Approval

The consequences of lack of approval include the risk of having nurses who do not meet educational requirements and who therefore have deficient preparation. However, the Law on Professions (Article 12) limits this risk. By law, non-approved schools are not allowed to issue certificates or academic degrees, and such conditions must be mentioned in their documents and advertising. (Source: General Law on Professions, 1975).

Ten-Year Projections for Approval Processes

The approval processes are determined by Mexican laws. The academic standards of universities, schools of nursing and other higher education institutions are responsible for maintaining and improving these processes. It will be necessary to continue modifying current processes in order to guarantee improved health care for the population and to encourage the development of the nursing profession, including both nursing practice and nursing education.

The baccalaureate level will continue to be improved, while the master's and doctoral levels will be fostered with the goal of meeting social needs. In addition, increased participation in cross-disciplinary work teams under equal conditions with other professions will be encouraged.

Efforts will be made to further expand primary care and health care from the perspective of human rights and the perspective of health as a social phenomenon that interacts with other social, physical, environmental, economic, ideological, educational, cultural, and political factors.

The professional level of practicing nurses will continue to be reinforced. Attention also will be paid to integral education that focuses on learning to be, learning to do and learning to learn. Emphasis will be placed on the development of the discipline, critical judgement, the handling of therapeutic relationships, leadership and decision-making skills. Efforts will be made to increase the number of nursing schools that offer cultural, sports, and other activities with students from other professions.

Emphasis also will be placed on the participation of other Colleges of Professionals (Colegios de Profesionistas) in order to encourage the participation of nurses in the approval processes and to reinforce the actions of the CNE toward this goal.

The laws of Mexico provide for the validation and equivalence of the education of foreign professionals as well as Mexicans who study abroad. It would be useful to develop a network for the exchange of information on the possibilities of education among the three countries.

History of the Accreditation Process

Since there is no accreditation process conducted by an organization of nurses that is independent from nursing schools, efforts thus far have focused on assessment. Some self-assessment has been conducted since the creation of the first nursing school early in the 20th century.

In 1952, with the creation of the teaching major in nursing, self-assessment was systematically incorporated. Self-assessment is promoted in all professional events that are organized on a regular basis. These processes have been reinforced by government policies implemented across the country beginning in the 1970's and have continued to evolve. As a result of the establishment of systematic and continuous assessment processes in most nursing schools, information can be obtained for the modification of curricula and educational programs.

Several initiatives aimed at establishing standards for the eventual purpose of setting up an accreditation process have been carried out over a number of decades. These initiatives concluded with the drafting of regulations by the CNE, with the participation of nurses from across the country, State Colleges of Professionals (Colegios de Profesionistas) and health and educational institutions. This proposal, which includes standards for the practice and education of nurses, is pending approval from the Congress (Chambers of Representatives and Senators). Once this proposal is approved, it shall be the legal basis for the regulation of the profession.

Various groups across Mexico have organized to work on the standards methodology and the drafting of accreditation standards. On November 13, 1993, the Colleges of Professionals (Colegios de Profesionistas) were entrusted with the responsibility of developing accreditation and certification systems for each of the professions participating in the NAFTA treaty. This was ratified in writing to CNE by the Undersecretary of Higher Education and Scientific Research for the SEP. The Committee for the National Accreditation and Certification System for the Nursing Profession (Sistema Nacional Para la Acreditación y la Certificación de Enfermería, or SNACE) was created in January 1994 to develop the project and oversee its implementation across the country. This can be considered a response to NAFTA. The Committee is made up of CNE, representatives from the Health Secretariat (Secretaría de Salud), FENAFEE and State Colleges and Associations (Asociaciones y Colegios Estatales).

FENAFEE has developed an assessment tool for nursing schools that is based on the prospective analysis methodology. In 1985, an instrument also was developed that relates to the structure, process and result standards. The relevant indicators were developed and a pilot test has been conducted.

Current Status of the Accreditation Process

Self-assessment is in its beginning stage and involves teachers, authorities, students and health care professionals. In addition to the self-assessment performed at schools, the central entities of the educational organization to which schools belong (universities, institutes, etc.) perform an assessment of the schools and supervise them.

A strength of this assessment process is that it is well established at present due to the educational standards in effect in each educational institution. However, one weakness is that there are no independent organizations that perform the accreditation process. This issue should be resolved.

The data in the section on the impact of approval processes are the same for accreditation. It is expected that the accreditation process will cover all nursing schools and that those schools meeting the requirements will be accredited.

Ten-Year Projections for the Accreditation Process

It is expected that a project on accreditation processes will be created with the participation of nurses practicing both in health care and educational programs. The project will be executed in stages in accordance with school levels, beginning with the baccalaureate level. For this process to take place, the following activities are necessary:

- Consolidation of the Accreditation groups.
- Drafting of standards for accreditation with the participation of nurses working in health services, nursing schools, State Nurses Colleges (Colegios Estatales de Enfermería), Regional School Associations (Asociaciones de Escuelas Regionales) and the federation grouping them together: FENAFEE.
- Dissemination of information on these processes to health and education institutions and organizations and solicitation of their support for the activities to be conducted during the planning and implementation stages.

Approval of Nursing Education Programs in the United States

Julia E. Gould, MS, RN
Georgia State Board of Nursing

Executive Summary

Key Stages in the Development of Approval Processes

The use of untrained "nurses" and the lack of regulation for nursing led to the promulgation of the first Nurse Practice Act in North Carolina in 1903. The concept for the present National Council of State Boards of Nursing (NCSBN) evolved at an American Nurses Association (ANA) convention in 1912. In 1945, the ANA by-laws provided for a Bureau of State Boards of Nurse Examiners to establish a forum to assist State Boards and to harmonize the interpretation of state laws and regulations. In 1947, the ANA Board of Directors established the Council of State Boards of Nursing which was comprised of one nurse representative from each State Board of Nursing. In 1974, the Council of State Boards of Nursing appointed a task force to study the Council's relationship to the ANA. In 1978, the NCSBN was created as a separate organization.

The development of a national licensing examination, currently administered in all jurisdictions, began during the 1940's. It evolved from a series of medical model sub-sets to a comprehensive nursing examination; from a paper and pencil format to a computerized one; from separate scores to a single score to pass/fail with a common passing standard.

Over the years, nursing curricula and the regulation and accreditation of nursing education programs have been influenced by the work and publications of the National League for Nursing (NLN), the Tylerian model, Mager's instructional objectives, publications by many nursing educators and consultants, and the varying relationships among regulatory and accrediting bodies.

Several major studies in this century have identified issues and trends in nursing education and supported the need for standards and greater uniformity. Studies include those by Esther Lucile Brown, Jerome Lysault, Mildred Montag, Josephine Goldmark, the National Commission on Nursing Implementation Project, NCSBN, the ANA, the American Association of Colleges of Nursing (AACN), the NLN, the Pew Commission and others.

Summary of Current Status

Nurse Practice Acts and rules/regulations provide authority for Boards of Nursing to regulate nursing education in each of 56 jurisdictions. The approval process and status generally denotes that nursing education programs are developing, have full approval, or have conditional or pro-

bationary approval. Usually, a process is in place to withdraw approval for continued, documented noncompliance with the rules. Boards may monitor and evaluate nursing education programs through review of annual reports and/or self-studies, passing rates of first-time writers on the National Council Licensure Examination (NCLEX), and site visit reports.

Projections for Approval Processes over the Next Ten Years

Approval processes must be maintained and strengthened while enabling greater flexibility to achieve compliance and increased input from educators, practice setting personnel, and consumers. These processes will be influenced by changes in nursing education, practice and health care, use of diverse practice settings, and increasing need for technological skills.

History of Approval Process

Background to Establishment of Approval Processes

Key Factors

At the turn of the 20th century, a large proportion of those practicing as "nurses" had never received any training, yet no legal restrictions prevented them from presenting themselves to the public as fully trained graduates. The need for legislation to control the practice of nursing and the importance of having well-organized state associations to help secure it were recognized by the growing number of trained nurses. The idea of nurse registration as a means of separating trained from untrained nurses was not a new one. It had been instituted in South Africa in 1898; Natal in 1899; New Zealand in 1901; and Great Britain in 1902. For the United States, however, such legislation would have to be handled on the state rather than the federal level (Kalisch & Kalisch, 1995, p. 192).

In 1898, Sophia Palmer made the first public statement on the subject of nurse licensure in a paper read before the New York State Federation of Women's Clubs. As a result, the Federation passed a resolution favoring the establishment of a Board of Examiners chosen by the state society of nurses and recommending the inclusion of nursing in the list of professionals supervised by the Board of Regents of the State University of New York (Kalisch & Kalisch, 1995, p. 192).

An event that emphasized the immediate need for nurse registration occurred in 1900, when the Philadelphia County Medical Society and the College of Physicians of Philadelphia announced that they were launching a school of nursing that would fully prepare students in only 10 weeks. Simultaneously, several correspondence schools began operating on a wide scale (Kalisch & Kalisch, 1995, p. 192).

Key Organizations

In September 1901, the first meeting of the International Council of Nurses (ICN) was held in Buffalo, New York. Mrs. Bedford Fenwick, President, proposed a resolution ".... that it is the duty of the nursing profession of every country to work for suitable legislative enactment regulating the education of nurses and protecting the interests of the public by securing state examinations and public registration with the proper penalties for enforcing the same". Following the ICN Congress, the introduction of nurse registration bills in the various state legislatures was generally preceded by the formation of state nurses associations composed either of individuals or of individuals and organizations, such as alumnae associations (Kalisch & Kalisch, 1995, pp.192-193).

Date of Establishment of Approval Processes

Founding Organizations

Boards of Nursing

In 1903, in response to a bill presented by the state nurses association, North Carolina became the first state to pass legislation requiring nurse registration. However, completion of a nurse training course was not required for registration. Any applicant, regardless of training or experience, who passed a state-administered examination was entitled to a certificate and a license to practice. The responsibility for developing the examinations and issuing licenses was assigned to a new Board of Nurse Examiners composed of two physicians and three nurses (Kalisch & Kalisch, 1995, p. 194).

Among the initial state registration laws, New York's was considered to be the most progressive. Until its promulgation, nurses' training could range from three years to none at all. To be eligible for registration in New York, however, nurses had to graduate from training schools approved by the Board of Regents. Even nurses trained outside the state who were practicing in New York were required to register according to the law in order to continue working. As a consequence, some schools in other states altered their methods of training and expanded their curricula to conform to New York's requirements (Kalisch & Kalisch, 1995, p. 194).

The New York requirements specified the amount of practice and instruction in subjects considered essential for the development of professional knowledge. Obstetrics, not offered by many nurse training schools, was made a curricular requirement early on by the State Board. One hospital that had met all the requirements except for the nursing of sick children, opened a children's ward to enable its students to receive state approval (Kalisch & Kalisch, 1995, p. 194).

National Council of State Boards of Nursing

At a special conference on state registration laws held during the ANA convention in 1912, it was voted that a committee be appointed for the purpose of arranging an annual conference for nurses involved with State Board of Nursing work, to be held during the larger ANA meeting.

By 1914, 39 Boards of Nurse Examiners were operating. The *American Journal of Nursing* published a January 1914 editorial stating that the time had come for a formally organized federation of State Boards of Nurse Examiners that would affiliate with the ANA.

In 1945, the ANA by-laws provided for a Bureau of State Boards of Nurse Examiners, which would establish a forum to help State Board members within their own states and attempt to harmonize the interpretation of laws and regulations. In 1947, the ANA Board of Directors appointed a committee comprised of one nurse representative from each State Board of Nursing. That body was recognized as the ANA Council of State Boards of Nursing. At the 1950 meeting of this group, the representatives of the 40 State Boards of Nursing voted unanimously to continue this relationship.

In 1974, the Council of State Boards of Nursing appointed an ad hoc committee to examine the possibility of the Council establishing itself as a self-governing, incorporated body responsible for all aspects of State Board work. It was becoming apparent that the ANA by-laws provided too close a relationship between the State Boards of Nursing, as the administrative agencies of state government responsible for the licensing of nurses, and the national professional association of nurses. In the current structure, it appeared that the Board of Nursing representatives serving on the Council were more representative of the professional association than the regulatory body.

In 1978, the National Council of State Boards of Nursing (NCSBN), composed of member Boards of Nursing, was created as a free-standing organization with a defined mission, objectives, and goals. The mission of the NCSBN is to promote public policy related to the safe and effective practice of nursing in the interest of public welfare. NCSBN strives to accomplish this mission by acting in accordance with the decisions of its member Boards on matters of common interest and concern affecting public health, safety and welfare. To accomplish its aims, the Council provides services and guidance to its members as they regulate entry into nursing practice, including the development and use of licensing examinations, continuing safe nursing practice, and nursing education programs (NCSBN, 1996).

Stated Objectives

State approval of a nursing education program assured students, employers of nurses, and the community that graduates were prepared as entry-level nurses who were able to provide safe and effective care to patients.

Key Features

State approval of nursing schools began during the first quarter of this century, at a time when many formal nursing education programs were being established. As these new schools began supplying the workforce with nurses, it became apparent that graduates of certain schools did not have the knowledge or skills to provide safe and effective nursing care. To address this unacceptable situation, leaders of the nursing profession called upon the state's established panel of experts to review the quality of the existing schools and set the minimum standards necessary for initiating a new program. The panels, or Boards of Nursing, were subsequently authorized to grant state approval to those schools that met specified standards (NCSBN, 1995, pp. 1-4).

Initial Structure of Approval Processes

In all jurisdictions, state legislators enacted statutes that conferred specific authorities and responsibilities upon state agencies, such as the Board of Nursing. Nurse Practice Acts were promulgated to provide for the selection (by appointment or election) of a Board of Nursing and to grant that Board the authority to regulate the practice of nursing within its respective jurisdiction. The purpose of a Nurse Practice Act is to protect the public health, safety, and welfare by and through the effective control and regulation of nursing education and practice (NCSBN, 1995, pp. 1-3).

While the Nurse Practice Act authorizes the Board of Nursing to regulate the nursing profession for the protection of the public health, safety and welfare, the administrative rules and regulations provide the guidelines to accomplish that authority. Rules and regulations, promulgated by the Board itself, specifically outline the

responsibilities of the Board, are tailored to the needs of its jurisdiction, and have the force of law. Revision of rules and regulations is common and reflects changes in the roles of nurses and in the knowledge, skills, and abilities required for safe nursing practice. In most instances, the Board is responsible for monitoring, on behalf of the public, nursing education programs within its jurisdiction to ensure that graduates are educated for safe and effective nursing practice. In some jurisdictions, this responsibility is assigned to another agency, such as the Board of Education (NCSBN, 1995, pp. 1-3).

Outline of Initial Processes

Consistent with the establishment of regulatory boards, early approval processes included review of annual reports submitted by the nursing education programs, establishment of standards for admission, curricula, graduation, and physical resources (such as classroom space, equipment, supplies, library, practice settings) by the Board of Nursing, and/or program site visits by Board members and/or staff.

Major Changes in Processes over Time

Reasons for Change

The approval of nursing education programs by Boards of Nursing cannot be considered in a regulatory vacuum or it would lose its ability to be responsive to the needs and protection of the public. Many variables influence the approval process: world events, changes in health care, shifts in educational focus, changing demography of students, emerging roles of nurses, major studies, and the relationship with accrediting and other regulatory bodies.

Nature of Changes

Evolution of the National Licensing Examination

The primary function of the Council of State Boards of Nursing was to develop and regulate the use of the State Board Test Pool Examinations (SBTPE). During the 1940's, Boards of Nursing were pressured to develop the licensing examinations and correct the papers for the rapidly increasing numbers of candidates. In 1942, the Committee on Nursing Tests of the National League of Nursing Education (NLNE) was requested by the Subcommittee on State Boards of Nurse Examiners to assist in the cooperative preparation of licensing examinations. This request led to the development of the SBTPE in 1944 as a paper and pencil test.

In 1982, the SBTPE changed from a five-part medical model test to a comprehensive nursing examination called the National Council Licensure Examination (NCLEX), offered twice a year over a two-day period for registered nurse candidates. The examination for licensed practical nurses was administered biannually in one day. The results for the NCLEX changed from separate scores to a single score. In 1988, results were reported as pass/fail.

In 1994, computerized adaptive testing (CAT) for the NCLEX was initiated on a year-round basis. The length of the test period ranges from approximately one and one-half hours to a maximum of five hours.

The Shift of Nursing Education from Hospitals to Institutions of Higher Education

In the years following World War II, the quality of nursing education came under severe criticism. Hospital-based diploma programs, where most nurses were educated, frequently suffered from poor levels of teaching, inadequately prepared teachers, and a significant dependence on students for services. (Kelly & Joel, 1995, p. 61).

In Esther Lucile Brown's 1948 report, *Nursing for the Future*, the necessity for official examination of all schools, publication and distribution of lists of accredited schools, and public pressure to eliminate nonaccredited schools was emphasized. She also recommended that efforts be directed to building basic schools of nursing in universities and colleges that were sound organizationally and financially, adequate in facilities and faculty, and well-distributed to serve the needs of the entire country. However, in his 1970 report, *An Abstract for Action*, Jerome Lysault concluded that many of the recommendations in the Brown Report remained unaddressed (Kelly & Joel, 1995, pp. 70-71).

In 1951, Mildred Montag designed a two-year course of study for "technical nurses" and implemented it in a funded project in selected two-year community colleges. From the 1950's on, college-based programs have increased and hospital schools have correspondingly decreased (Bevis & Watson, 1989, p. 23).

In 1965, the ANA issued its Position Paper on Education for Nursing, which stated that minimum education for professional nursing should be at the baccalaureate level; for technical nursing, at the associate degree level; and for assistants, at the vocational level. Thirty years hence, the struggle around this issue continues (Kelly & Joel, 1995, p. 64). North Dakota is the only jurisdiction requiring the baccalaureate degree for entry into professional practice.

Guidelines for Curriculum

In 1917, the NLNE published its *Standard Curriculum*, which was accepted by many Boards of Nursing. Described as an "optimum" curriculum so that schools could voluntarily improve their programs, it was developed at a time when state requirements were minimal and lacking in uniformity. It provided objectives, content, and methods for each course and listed materials, equipment, and bibliographies. In 1927, the *Curriculum* was revised, with the word *"Standard"* dropped from its title. In 1937, a third revision, *A Curriculum Guide for Schools of Nursing*, was published. In spite of subsequent major changes in nursing, the book was never again revised (Bevis & Watson, 1989, p. 22; Kelly & Joel, 1995, p. 70).

In 1949, Ralph Tyler's influential book, *Basic Principles of Curriculum and Instruction*, was published. The adoption of the Tylerian model and its institutionalization by regulatory and accrediting bodies at state and national levels had a massive impact on nursing education. Through the use of regulations, criteria, and the way in which site visitors were oriented, agencies mandated the use of a philosophy, concepts or strands, and behavioral objectives for all levels of nursing education. The outcome of noncompliance could be a change in Board approval or denial of accreditation (Bevis & Watson, 1989, pp. 22-29). Two other publications reinforced the Tylerian model: Bevis' *Curriculum Building in Nursing* (1973), and Mager's *Preparing Instructional Objectives* (1962).

Beginning in 1988, spurred by the National Nurse Educator conference in Philadelphia and the publication of revised accreditation criteria for baccalaureate and higher degree programs, the NLN's Council of Baccalaureate and Higher Degree Programs began to deinstitutionalize the Tylerian model through the "curriculum revolution" (Bevis & Watson, 1989, pp. 28-29). The curriculum revolution catalyzed transitions from sick care to health care promotion; from content-driven to reality-based curricula; from authoritarian to egalitarian relationships with students; and from memorization to critical thinking. In so doing, attention was focused on caring about people and fostering collaborative modes of practice.

In 1990, in response to this stimulus, the Georgia Board of Nursing adopted nursing education rules that have departed from the prescriptive, behaviorist paradigm in favor of user-friendly, flexible rules that still maintain quality (Georgia Board of Nursing, Rules and Regulations, 1995). Several other State Boards are in the process of revising rules and defining competencies.

Relationship with Accrediting and Other Regulatory Bodies

Boards of Nursing, and the nursing education programs that they regulate, benefit from the accreditation processes of the NLN and the regional accrediting bodies. Often, a symbiotic relationship exists. The NLN requests information about the Board approval status of a nursing program prior to its site visit. In turn, Board of Nursing site visitors often read the NLN and regional accrediting body self-studies in preparation for their site visit. Sometimes visits are conducted concurrently by Board and NLN representatives. On occasion, all three bodies visit at the same time.

In addition to regulation by Boards of Nursing, nursing education programs and/or their parent institutions are subject to regulation by other local, state, and regional agencies. For example, nursing education programs must meet standards set by the Occupational Safety and Health Administration (OSHA) and by those established under the Americans with Disabilities Act (ADA; NCSBN, 1995, pp. 1-5).

Practice settings used for student learning activities, including hospitals, home health agencies, and long-term care facilities, are required to adhere to regulations set by a number of agencies, such as the state Department of Public Health and the Health Care Financing Administration (HCFA). Practice settings also may seek voluntary accreditation from a national agency such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO; NCSBN, 1995a, pp. 1-5).

Qualifications of Board Members and Staff

The first Practice Acts were permissive in nature, which made compliance difficult to regulate. Hospital schools of all sizes felt no need to meet standards that might deprive them of student labor. Even those schools which chose to adhere to State Board standards found them not too difficult and subject to little follow-up. Most schools were approved on the basis of paper credentials (Kelly and Joel, 1995, p. 57). Programs were approved if they provided the required number of days in each of the designated services (Bevis & Watson, 1989, p. 27). The states that did employ nurse "inspectors" often ran into trouble withholding approval. Frequently, Board members were as poorly qualified as the heads of the schools and were subject to political pressure to grant approval. In 1938, New York passed the first mandatory licensure law, which was implemented in 1944 (Kelly & Joel, 1995, p. 57).

Nurse Practice Acts usually describe broad categories of educational and/or experiential qualifications for Board

members. Board members may be registered nurses and/or licensed practical nurses as well as consumers. They generally are representative of various geographic and demographic characteristics of the jurisdiction. Boards of Nursing now employ registered nurses who hold at least one graduate degree to participate in the regulation of nursing education.

Other Major Studies

In 1923, Josephine Goldmark's *Nursing and Nursing Education in the United States* was published. While the study focused on the proper training of the public health nurse, it included recommendations that remain pertinent today, particularly those related to the maintenance of legislated educational standards and the development and strengthening of university schools of nursing (Kelly & Joel, 1995, p. 67).

While Josephine Goldmark pointed out many of the weaknesses that existed in nursing education and recommended some changes, implementation proved difficult. In an overall effort to increase the quality of nursing schools, the ANA organized a Committee on the Grading of Nursing Schools, which published a final report in 1934 and attempted to establish minimum standards. One of these standards refers to approval by an appropriate state agency, such as the State Board of Nurse Examiners (Bullough & Bullough, 1966, pp. 18-19).

Several other publications include valuable information for those responsible for approval processes. In December 1987, in response to reports of widespread difficulties recruiting and retaining registered nurses, Health and Human Services Secretary Otis R. Bowen, M.D. established the Secretary's Commission on Nursing. The panel was established to advise the Secretary on problems related to the recruitment and retention of nurses and to develop recommendations and strategies on how public and private sectors could jointly address these problems and implement solutions for enhancing the adequacy of the supply of registered nurses. One of the recommendations, with concomitant strategies, stated that "schools of nursing, State Boards of Nursing, and employers of nurses should work together to ensure that the curricula are relevant to contemporary and future nursing practice, prepare nurses for employment in a variety of practice settings, and provide the foundation for continued professional development" (Secretary's Commission on Nursing, 1988, pp. 41-42).

In 1984, the National Commission on Nursing Implementation Project (NCNIP) was funded by the W.K. Kellogg Foundation to implement changes in nursing that were recommended by the 1983 National Commission on Nursing. The activities of NCNIP were designed to implement: differentiated practice; nurse-managed delivery systems; nursing information systems to track quality and cost of care; a process to move the nursing education system toward preparing two categories of nurses; ways to foster public understanding of nursing's contribution to health care research; and ways to translate the project goals to other groups. The outcomes of the project were published in 1989 as *Nursing's Vital Signs: Shaping the Profession for the 1990's.*

In the 1990's, the Pew Health Professions Commission published a series of reports examining health care needs, health professionals, and regulation.

Current Status of Approval Processes

Description of Approval Processes

Steps and Stages

The Nurse Practice Acts provide the authority for each Board of Nursing to regulate nursing education. The mechanism for accomplishing this is delineated in the Board's rules and regulations. Approval of a nursing program is a public action, determined by a Board of Nursing, which signifies whether compliance with the law and rules of the jurisdiction has been demonstrated.

Since each Board responds to the specific needs of its jurisdiction, variability of educational regulations across the country is significant. Some rules and regulations set detailed parameters for compliance, while others are more broadly framed and flexible. Generally, rules address areas including, but not limited to: organization and administration; curriculum; evaluation; faculty; students; resources; and performance of graduates.

Boards may develop general requirements for all levels of basic nursing education: practical/vocational, associate degree, diploma, baccalaureate degree, generic master's, and generic doctoral. Boards may also have regulations specific to each of these educational levels.

The United States has 56 jurisdictions that regulate nursing education and practice: the 50 states, the District of Columbia, American Samoa, Guam, North Mariana Islands, Puerto Rico, and the Virgin Islands. Five of these jurisdictions have separate Boards for registered nurses and licensed practice nurses.

Students can pursue five different tracks toward initial licensure as registered nurses: two-year associate degree programs, three-year hospital-based diploma programs, four-year baccalaureate programs, generic (entry level) master's programs, and generic (entry level) doctoral programs. Students may also seek initial licensure as licensed

practical/vocational nurses in shorter programs. Parent institutions include vocational/technical institutions, hospitals, community colleges, senior colleges, and universities. The parent institution may be public or private.

The approval process generally has more than one level which signifies that a program, whether developing or established, is or is not meeting all regulatory criteria. The specific title may vary among jurisdictions.

Initial approval for developing programs may proceed by stages, depending upon established criteria. Designated approval signifies documented compliance with the rules for such criteria as feasibility; regional body accreditation; approval by the governing body of the parent institution; financial resources; academic and physical resources; academic and organizational structure; plan for recruiting faculty and students and obtaining practice settings; curriculum development; faculty and student policies; and program evaluation. The development and implementation of a program usually involves ongoing communication/consultation with the Board staff, site visits to the parent institution and practice settings, submission of written reports, possible hearings, and meetings with the Board. The initial approval generally is in effect at least until the first class graduates.

Full approval is based upon an established time frame and criteria. It may include the review of an annual report and/or self-study, the passing percentage of first-time writers on the licensing examination (over a specified time period), or the most recent site visit report. Compliance must be demonstrated.

For programs that do not demonstrate compliance, approval status may change to conditional or probationary. Some jurisdictions allow the program some time to correct deficiencies before the approval status is changed, and/or have an appeals process.

Withdrawal of approval is a serious outcome that usually follows an extended period of documented deficiencies. Generally, enrolled students are permitted to complete the program or to transfer to another approved program.

Authority and Structures

In its *Profiles of Member Boards* (1994), the NCSBN published responses to the question of whether Boards approve generic, RN-BSN, or graduate programs. The responses are summarized in Table 1. The three Boards that do not approve programs are Mississippi, New York, and Puerto Rico. American Samoa and the Virgin Islands did not respond.

Table 1 Board Approval of Programs

Approval	Generic	RN-BSN	Graduate
Yes	51	14	9
No	3	41	46
No Response	2	1	1
TOTAL	56	56	56

Time Frame and Milestones

The time frame for approval varies within jurisdictions from one to eight years as follows: one year (9 jurisdictions); two years (1); three years (1); four years (10); five years (10); six years (2); and eight years (3). Sixteen Boards stated that the approval time varied, two Boards reported that the time frame was unspecified, and two Boards did not respond.

Decision and Appeals Processes

Board rules generally have stated appeals processes in place. Based on the information/documentation presented in an appeal, the Board of Nursing has the authority to either uphold or change its decision.

Monitoring and Evaluation Mechanisms

In the *Profiles of Member Boards*, Boards responded to questions about using first-time writers' passing rates on the NCLEX as one of the criteria on which approval was based. Thirty-two Boards responded yes; 20 responded no; and four did not respond. Acceptable passing rates ranged as follows for the Boards that responded: 60% (1 Board); 75% (9); 80% (5); and 85% (5). Eleven Boards used criteria that varied depending upon the national passing rate.

In the *Profiles*, Boards also responded to a question about granting approval to a program meeting national accreditation standards. Thirteen Boards responded yes; 35 responded no; and eight did not respond.

Boards may require that programs submit an annual report or a self-study at a specified time, often prior to a scheduled site visit. Since both public and private institutions are regulated, the Board may be the only repository for data about numbers of students, faculty (numbers of full-time and part-time; level of education), practice settings, preceptors, and trends within the jurisdiction.

Boards may specify changes that require approval or notification of the Board, such as: the phasing out of one program and the development and implementation of another; the discontinuation of a program; a change in the

parent institution; the implementation of a satellite or off-campus offering; major curriculum changes; affiliation with a new practice setting; the transition from quarters to semesters (or vice versa); or changes in the nursing or parent institution administration.

Most Boards have the authority to conduct site visits to monitor compliance with the Board's regulations. In June 1995, NCSBN released its publication, *Guidelines for Education Program Surveyors: A Series of Learning Modules*. The guidelines are primarily intended to help the nursing education program surveyor (Board member or staff) to learn the role of a site visitor. They can also be used by the experienced site visitor to gain new perspectives or to serve as a review.

While site visits share many commonalities among jurisdictions, they tend to vary according to the individual Board's rules/regulations or to pre-established criteria. Following are some major aspects and options of site visits:

- **Length of visit:** The visit may be one day or several depending upon such issues as advance or on-site review of program materials, the size of the program, the numbers of sites in which the program is implemented, the reason for the visit, the number of people interviewed, and whether visits to practice settings are scheduled. Site visits are generally scheduled in advance, although the lead time may vary.
- **Agenda:** The site visit agenda may be set by the Board or negotiated. The site visitors, who may consist of Board members, Board staff or a combination, may request and review a wide variety of program materials. These include materials pertaining to: organization and administration; curriculum; faculty; students; preceptors; performance of graduates; educational facilities and resources; minutes; budget; contracts with practice settings; contracts with affiliating educational settings; and any other materials that the program faculty may wish to provide.

  During the site visit, meetings are often scheduled with college administrators, faculty, students, non-nursing faculty and staff, representatives of practice settings, and the advisory committee.

  In the *Profiles*, Boards responded to a question about approval of clinical facilities as follows: approval with a site visit (22); approval without a site visit (4); no approval (26); did not respond (4).
- **Reporting:** Generally, the report is summarized for representatives of the program either verbally or in writing. Some Boards provide a draft of the written report to the faculty for review and clarification prior to its review by the Board. The site visit report may be reviewed by a Board-appointed committee of Board members and/or educators with recommendations provided to the Board referring to the state of approval or a summary of comments on the program. The report also may be presented directly to the Board by the site visitors. A final written report is sent to the program with a specified time for a response. Boards may ask for an evaluation of the site visit.

Strengths of Current Approval Processes and Issues for Consideration

Perceived Strengths

- The protection of the public through the establishment of uniform standards for nursing education.
- Provision of guidelines for parent institutions or existing programs which are in the process of developing and implementing a new program.
- Facilitation of interjurisdictional endorsement of registered nurses.
- Facilitation of educational mobility/articulation within, or outside of, the jurisdiction.
- Establishment of standards by which the applications of nurses who have graduated from schools outside the United States can be evaluated.
- Availability of a consistent mechanism for educators to participate in the regulatory process through service on the Board or Board-appointed committees, review of proposed rules, and options for the conduct of the site visit.
- The process invites educational consultation by Board staff and/or Board members.

Issues to be Considered

- The blurring of education among students in associate degree, diploma, baccalaureate, and generic graduate programs, all of whom take the same licensing examination and are issued the same legal title, may raise the question of whether several different versions of regulatory language and processes are needed.
- The sole reliance on accreditation by a national organization for Board approval places responsibility on an organization not accountable to the citizens of the jurisdiction.
- Differences in regulatory philosophy and regulatory representatives have a tremendous impact on the approval process. That process currently ranges from participatory to perscriptive.

Impact of Approval Processes

Incentives for Undertaking the Approval Process

- Nursing programs that lead to initial licensure must seek and maintain Board approval; failure to do so violates the jurisdiction's Nurse Practice Act. The graduates of non-approved programs are not eligible for licensure.
- Programs leading to initial licensure must have Board approval in order to seek accreditation by the NLN. Regional accrediting bodies also review documentation of approval.
- Nursing programs use Board approval status in their publications, recruitment literature, and communication with the public.

In some states, RN-BSN programs have the option of seeking Board approval. Such programs may seek approval because a separate licensing examination for baccalaureate graduates may be developed in the future, financial support for the program may depend upon approval, or the military may require a candidate to have graduated from an approved program.

Number of Schools Approved/Not Approved

According to the NCLEX-RN Registered Nurse Education Program Codes currently in use, there are 154 diploma programs; 912 associate degree programs; and 537 baccalaureate degree programs. Generic master's and generic doctoral programs are coded with the same 500 number system as baccalaureate programs. In some instances, for example, the University of Colorado, the degree (ND) is designated beside the name of the university (NCSBN/ETS, 1995).

One cannot assume that programs that have never opened (but somehow were assigned a number), have closed, or have had approval withdrawn are not included on this list. Presumably the codes are provided for graduates of programs who may still be candidates for licensure. The approval status of programs is public information. Boards of Nursing also report the approval status of programs and plans for the opening and closing of programs to the NLN on an annual basis.

Implications of Non-Approval

See "Incentives" section.

Measured Improvements in Nursing Education

See "Strengths" section.

Projections for Approval Processes Over the Next Ten Years

Status of Approval Processes

Approval processes must be maintained in order to protect the public. However, the regulatory process will need to be impeccable, be responsive, and increasingly involve the participation of educators, practice-setting personnel, and consumers.

Modifications to Current Processes, Expansions, and Deletions

If the approval processes are modified, they should become more flexible and encourage participation of faculty, students, and practice-setting personnel. This does not imply that the standards will be lowered; quite the contrary. Individuals who become involved in the regulatory process share accountability for its quality.

Education rules and approval processes must be flexible if they are to be responsive to changes in health care, consumer needs, and the roles of nurses and nursing. The following factors will affect nursing education and the approval process:

- Associate degree and diploma programs are likely to decrease in number. It will be appropriate to make a decision regarding the baccalaureate degree as the entry-level education for registered nurses. Decisions will also need to be made about other levels of licensing examinations.
- The use of diverse practice settings, particularly community settings, will require close evaluation of the interaction between the unlicensed student and the faculty member. The issue is safety for the patient/client and the student. Many educators and Boards are wrestling with this issue, since a prescribed faculty-student ratio may need to be evaluated and revised when the faculty member and student may be separated by several miles. The use of preceptors is not a panacea, since responsibility for a preceptee adds considerably to the workload of a registered nurse.
- Technological skills will become increasingly important for students, faculty, and practice-setting personnel. Perhaps students in community practice settings will take interactive video cameras or computers with them in order to establish contact with the faculty member and/or another health care provider at a distant site.
- Faculty may need to examine core curriculum requirements and opt for more social than natural sciences.

- Undergraduate nursing education will need to be refocused to incorporate critical thinking, relationship skills, case management skills, and primary care skills (Lindeman, 1995).
- Increasing numbers of Boards may decide to regulate graduate education, particularly as advanced nursing programs increase.

International Interest in Approval Processes

With the increasing focus on cultural diversity in curricula, it is hoped that exchange programs can be implemented, as there is much to learn from nurses in other countries. Nurses are already communicating on the Internet, consulting internationally, and collaborating on research.

The approval process becomes important as the mutual need for licensure of registered nurse students and faculty occurs. Boards may be petitioned to waive licensure requirements for a faculty member from another country who wishes to join a U.S. faculty for a specified academic term. Board statutes and regulations generally address the requirement for current licensure of all registered nurse faculty.

Baccalaureate and graduate nursing programs may soon require a second language as an essential part of the curricula. Many communities have diverse ethnic populations whose first language may not be English.

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Accreditation of Nursing Education Programs in the United States

Sandra Lewinson, EdD, RN
National League for Nursing

Joyce Murray, EdD, RN, FAAN
National League for Nursing

Executive Summary

Key Stages in the Development of Accreditation Process

The National Nursing Accrediting Service (NNAS) was established on January 1, 1949. It represented the unification of accrediting activities formerly carried out by the National Organization for Public Health Nursing (NOPHN), the National League of Nursing Education (NLNE), the Association of Collegiate Schools of Nursing (ACSN), and the Council on Nursing Education of the Catholic Hospital Association. The National Nursing Accrediting Service (NNAS) was established to foster closer relationships among the various nursing groups who had been responsible for accrediting activities. Criteria that had been agreed upon by all of the organizations were brought together and published under the heading, *Manual of Accrediting Educational Programs in Nursing* (Kelly, 1985). The NNAS was responsible to a Joint Committee on Unification of Accrediting Activities with representatives from nursing organizations, the American Medical Association (AMA), the American Hospital Association (AHA), and regional associations in higher education.

In 1952, the NLNE became the National League for Nursing (NLN) and was officially recognized by the U.S. Department of Education as the accrediting body for all nursing education programs. The NLN is recognized as the professional organization accountable to the public, its members, and to the profession for assuring quality nursing education and practice. With increasing concern for health care in diverse communities, a changing health care delivery system, and the move towards outcome based criteria, the NLN continues its work towards maintaining the trust of the public it serves.

Summary of Current Status of Accreditation Process

The National League for Nursing accredits four levels of nursing education (associate degree, baccalaureate and higher degree, diploma, and practical nursing) in the United States and its territories. It is the only national professional organization to represent the educational needs of all nurses. Each of four educational councils within the NLN has its own criteria and guidelines for program evaluation, program evaluators, and Board of Review. The accreditation policies and procedures are common to all four educational councils. A set of organizing common core criteria was recommended by the Board of Governors in June 1995 and will be implemented by January 1997.

During the NLN voluntary accreditation process, programs engage in an intensive self-study and prepare a report to identify both program strengths and areas needing attention. Following completion of the self-study, the program is reviewed for either initial or continuing accreditation by trained, volunteer program evaluators. Recommendations of the program evaluators are presented to the programs under review and are forwarded to an elected Board of Review. The Board of Review evaluates the program, comes to consensus, and renders the final accreditation decision.

Projections for Accreditation Process Over the Next Ten Years

NLN voluntary accreditation will continue to assure the public of quality nursing education. The NLN will computerize the self-study report as well as the operations of the division of accreditation; develop a national nursing database; accommodate to the changing demands of higher education, students, and the health of diverse communities; and move into the international arena of quality assurance in nursing education and practice.

History of the Accreditation Process

Nursing's history contains a rich legacy of leaders and major studies aimed at improving nursing education and practice. Prior to the establishment of one accrediting agency, standards and quality of educational programs and practice rested with several nursing organizations. The background, the establishment, stated objectives, and the initial structure of the accreditation process follow.

Background to the Establishment of the Accreditation Process

Key factors

Studies conducted early in this century revealed appalling practices in nursing education programs. Education of nurses was conducted on an apprenticeship basis; the quality of teachers was poor; formal instruction was erratic, uncoordinated, and frequently sacrificed to the needs of the hospital; and students were often poorly selected . The Brown Report in 1948 found slow progress in improving these inadequacies. Brown emphasized the necessity for official examination and accreditation of all schools, publication and distribution of lists of accredited schools, and public pressure to eliminate non-accredited schools (Kelly, 1985) .

Nursing educational programs were being accredited by several different nursing organizations with minimal success in overall improvement. The development of accreditation for all programs was seen by some nursing leaders as a last chance for improvement.

Key organizations

The American Society of Superintendents for Training Schools of Nurses in the United States and Canada (ASSTSN) was founded in 1893 to promote high quality and standards in the newly formed nurses' training schools and to assure the public of the excellent quality of nurses that graduated from them. In 1912, the ASSTSN reorganized and became the National League of Nursing Education (NLNE).

In 1949, the National Nursing Accreditation Service (NNAS) formed and attempted to unify the multiple accreditation activities in the United States. Several organizations had formed during the first half of the 20th century and were interested in the educational standards and practice of specialty groups. Organizations involved in accrediting activities prior to 1952 included the National Organization of Public Health Nursing (NOPHN), the NLNE, the Association of Collegiate Schools of Nursing (ACSN), the National Association of Practical Nursing, and the Catholic Hospital Association. In 1952, when the NLNE united with the National Organization of Public Health and the Association of Collegiate Schools of Nursing, it became known as the National League for Nursing (NLN). Accreditation became, and continues to be, one of the NLN's major goals and responsibilities.

Two other nursing accreditation agencies were also established, for nurse anesthetists and for nurse midwifery programs. A separate report on accreditation of nurse anesthesia educational programs is included later in this monograph; a brief history on nurse midwives is presented here.

Nurse-midwifery was established in the United States in the early decades of this century. The first nurse midwives were from Great Britain and many U.S. nurses went to Great Britain to be educated. Midwifery programs in the United States were established during the 1930's and 1940's and efforts were made to compile data on programs and their graduates. The NOPHN included a Nurse-Midwifery Section, which formulated a professional philosophy, discussed curriculum and developed a roster of nurse-midwives. When the NOPHN was dissolved in 1952, its activities were assumed by the NLN.

In 1955, the American College of Nurse-Midwifery (ACNM) was established. A key goal of the new organization was the evaluation and approval of nurse-midwifery

services and education programs. At an annual meeting of the ACNM, a special Committee on Curriculum and Approval was formed and continued until 1974 when it became the Division of Approval within the ACNM's overall structure. In 1979, it became the Division of Accreditation (ACNM DOA Policies and Procedures, 1994).

Establishment of the Accreditation Process

Founding Organizations and Key Features

The NNAS, established on January 1, 1949, provided services to programs previously accredited by other organizations and conducted a re-study of all basic programs. This study consisted of questionnaires and one-day visits to all schools. Information was given voluntarily. Upon review of this survey data by appropriate Boards of Review, programs were approved for temporary accreditation for five years or not approved (Nahm, 1974). This was the first comprehensive accrediting process. In 1952, all accrediting activities were organized into the newly formed NLN, which was the first nursing education organization to be recognized by the U. S. Department of Education.

Stated Objectives

The NLN accreditation program is founded on the belief that specialized accreditation provides for the maintenance and enhancement of educational quality, provides a basic assurance of program improvement, and contributes to the improvement of nursing practice. The following stated purposes of the NLN Division of Accreditation are found in the *Policies and Procedures of Accreditation for Programs in Nursing Education*, Sixth Edition (NLN, 1990, p.3).

1. To foster the continuous development and improvement in quality of educational programs in nursing throughout the United States and its territories.
2. To evaluate nursing programs in relation both to their stated purposes and objectives and to the established criteria for accreditation.
3. To involve administrators of the governing institutions and the administrators, faculties, and students of nursing programs in the process of continuous self-study and improvement of their programs.
4. To bring together practitioners, administrators, faculty and students in an activity directed toward improving educational preparation for nursing practice.
5. To provide an external peer-review process.

Initial Structure of the Accreditation Process

Key Organizations Involved

When NLN became responsible for the accreditation of all entry-level nursing education programs, the Department of Baccalaureate and Higher Degree Programs assumed responsibility for accreditation of all programs under the auspices of four-year colleges and universities; a Department of Diploma and Associate Degree Programs assumed responsibility for accreditation of programs under the auspices of hospitals and of junior or community colleges. A Department of Associate Degree Programs was developed at a later date.

The agency membership of each department accepted responsibility for the development of criteria to be utilized for evaluating the programs. Site visitors and Board of Review members were selected from accredited schools. Board of Review members were responsible for decisions related to accreditation status. These practices closely resembled those of regional accreditation in higher education.

Levels of Authority and Control

The NLN has been recognized by the U.S. Department of Education, by the Commission on the Recognition of Postsecondary Accreditation (CORPA), and by the NLN membership as the national accrediting body for nursing in the United States and its territories. The NLN is organized into the following divisions, Accreditation, Education, Finance, Communication, Customer Service, Assessment and Evaluation.

Under the Division of Education are four educational councils that represent four different levels in nursing education in the United States and its territories. The educational councils are: The Council of Practical Nursing Programs, The Council of Diploma Programs, the Council of Associate Degree Programs, and the Council of Baccalaureate and Higher Degree Programs. Each council has either a standing accreditation committee or an ad hoc accreditation committee that addressees accreditation issues related to their specific councils. For example, each council develops council-specific criteria and guidelines used in the accreditation process. The NLN Board of Governors, which maintains overriding authority over all NLN divisions and is held accountable by the U.S. Department of Education and CORPA, appoints a member from each educational council to serve on the broader NLN Accreditation Committee. The NLN Accreditation Committee, which includes additional members from service and higher education, addresses

trends in higher education and issues of accreditation affecting all four councils and makes recommendations to the Board of Governors.

Outline of Initial Process

The initial accrediting process established by the NNAS included a program of temporary accreditation. School data were collected by questionnaires and site visit. If approved after review by the appropriate Board of Review, schools were placed on the list of temporary accreditation for a five-year period. If a school were placed on the temporary accreditation list, it was given five years to achieve full accreditation. Assistance was provided through self-evaluation forms, consultation services, and regional conferences.

Current Status of Accreditation Process

Description of Current Accreditation Process

The purpose of accreditation is to improve nursing education and practice. The process for accomplishing this includes a programmatic self-study, on-site review by program evaluators, and evaluation by a Board of Review. The Board of Review makes the final decision regarding accreditation and it is publically announced.

Steps in the Accreditation Process

For initial and continuing accreditation, programs complete forms sent to them by the NLN for accreditation one year prior to the visit date. For initial accreditation, programs contact the NLN to state their intention to apply for initial accreditation. Eligibility requirements for accreditation must be met before initial accreditation can be sought (NLN, 1990, p.9).

Program evaluators are selected to visit programs by NLN staff based on program type, needs, geographical location, size, and other specific criteria. Program evaluators are selected from the membership of each council, must meet council specific criteria, and undergo a two-day training session. The final selection of program evaluators is made by the other candidates who attend the training session and evaluate each others' abilities, such as working as a team member, understanding the purpose and goals of accreditation, being knowledgeable about trends and issues in nursing education and practice, and showing awareness of the health care needs of culturally diverse populations. Each council maintains a current list of program evaluators that is shared with programs to be visited. Programs are asked to identify any evaluators with whom they may have a conflict of interest, such as former consultants or faculty members.

Programs undergo a period of self-study prior to the visit and submit a Self-Study Report to be reviewed by the program evaluators and by the Board of Review. Each program uses the criteria and guidelines designated by the educational council of which they are agency members. For example, a baccalaureate or master's degree program proceeds with a self-study using the *Criteria and Guidelines for the Preparation of Self-Study for the Council of Baccalaureate and Higher Degree Programs*, 1991. During the self-study period, programs are able to identify their strengths as well as areas that need improvement.

The Self-Study Report is used by program evaluators and Board of Review members as one of the primary documents to evaluate the program. The Self-Study Report presents evidence of how the program meets the specific criteria designated by their educational council.

Between two and five program evaluators visit a program for two to four days depending on the type of program, number of off-site satellites/campuses, and/or specific needs of the program. NLN staff members work with program directors and with program evaluators to determine the right size and mix for the accreditation visit.

The purpose of the accreditation visit is to amplify, clarify, and verify the program's written materials and to evaluate how well the program meets the criteria. During the visit, the program has an opportunity to highlight the material written in their self-study. Evaluators are able to fully view the program from the added dimension that only first-hand experience can provide.

During the visit, program evaluators prepare a Program Evaluators' Report that is presented to the program at the end of the visit. During the exit interview, evaluators make criteria-based recommendations and recommend an accreditation status, such as initial or continuing accreditation. The Program Evaluators' Report, with the evaluators' recommendations, is then forwarded to the Board of Review for final decision regarding a program's accreditation status.

The Board of Review is comprised of a panel of ten elected NLN individual members who have agreed to serve on the Board for a three-year term. A member may be elected twice to serve two consecutive three-year terms. Each educational council determines the council-specific criteria for membership on a Board of Review and holds annual elections for its members. Each panel of a Board of Review is comprised of eight nurse educators, one public member and one service representative. The number of

Boards of Review per year for each council is determined by the number of programs being reviewed.

Each program that will be presented at the Board of Review is assigned to a primary reviewer who is part of a team consisting of three Board members. The primary reviewer reviews the program's self-study, any supplemental material submitted by the program, and the program evaluators' report and presents the program to the larger Board of Review. Following deliberations, the Board votes on the accreditation status and makes criteria-based recommendations.

Program directors/deans/coordinators are notified of the time of their review by the Board of Review and are welcome to attend the meeting. During the review, the program representative has an opportunity to clarify the discussion by the Board and also may ask questions following the review.

Time Frame and Milestones

Certain conditions must be met before a program is eligible for NLN accreditation. A program interested in obtaining NLN accreditation submits a letter of intent to apply for accreditation. Programs must meet specific eligibility requirements in order to gain NLN accreditation. Eligibility for initial accreditation include the following requirements (NLN, 1990, pp. 9-10):

1. The institution offering the program is legally authorized to grant the credential (degree, diploma, or certificate) to which the program leads.
2. The institution offering the program and granting the credential is accredited by the appropriate accrediting agency.
    a. If the program is controlled by a college, university, or technical institution that is part of the system of higher education and grants a diploma or certificate or an associate, baccalaureate, or higher degree in nursing, the institution is accredited by the appropriate commission of the regional accrediting association.
    b. If the program is controlled by a hospital and grants a diploma, the hospital is approved by the Joint Commission on Accreditation of Health Care Organizations.
    c. If the program is controlled by a vocational school and grants a certificate, the school is approved by the appropriate state agency for vocational education.
    d. If the school is independent and has state approval to grant an associate, baccalaureate, or higher degree in nursing, the school is accredited by the appropriate commission of the regional accrediting association.
3. The program is currently approved without qualification by the state agency that has legal authority for education programs in nursing. This policy is not applicable to those programs in nursing over which the State Board of Nursing has no jurisdiction (i.e., master's degree programs or programs admitting previously licensed nurses).
4. The program has graduated at least one class of students.

Once eligibility is determined by the school and the NLN, the program receives materials necessary to initiate the process. Usually the programs initiate the process one year prior to their proposed site visit date.

Authority and Structures

Board of Review

The Board of Review derives its authority through the executive committee of its council from the NLN's Board of Governors (NLN, 1990, p. 21). The Board of Review has the authority to determine accreditation status based on review of a program's self-study report, supplemental materials, the Program Evaluators' Report, discussion with the program evaluators, and discussion with the program representative (For the range of Board actions, see NLN, 1990, pp. 24-26.)

Appeal Panel

The authority of the three-member appeal panel is derived through the executive committee of its council from the NLN Board of Governors (NLN, 1990, p. 28). Appeal panel members, which include two peers from the council and one non-nurse educator, are nominated and elected by council members. Appeal panel members serve a three-year term and may be elected to serve two consecutive terms. When convened, the appeal panel has the authority to review the original accreditation decision made by the Board of Review, the supplemental materials, the program's rationale for appeal, the program evaluators' report, and the school's presentation in support of its appeal. The decision of the appeal panel regarding accreditation status is considered final.

Decision and Appeal Process

The following summarizes the actions that can be taken by a Board of Review:

Initial Accreditation

1. Initial accreditation is granted for five years with or without recommendations; and with or without a progress report to be submitted in a designated period of time to another Board of Review; with specified conditions or combinations of the above. Initial accreditation of a nursing program is effective as of the date it is granted by the Board of Review and is retroactive to the 12-month period prior to the date of the accreditation site visit.
2. Initial accreditation is deferred (this decision is not appealable). The Board will defer accreditation of a program when evidence suggests that criteria can be met by the program in a short period of time. The Board identifies the criteria that have not been met, makes recommendations, and requests either a supplemental report or a supplemental report and a revisit within two years. The Board of Review in two years will review the supplemental report, the specific recommendations in the original letter of deferment, and the new program evaluators' report (if another visit is made), and will determine if the program is to be granted initial accreditation. If initial accreditation is granted, the program is placed in the original five-year cycle calculated from the date of the first accreditation site visit. Initial accreditation is retroactive 12 months prior to the date of the first accreditation site visit.
3. Initial accreditation is denied.

Continued Accreditation

1. Continued accreditation is granted for eight years with or without recommendations; with or without a progress report to be submitted in a designated period of time to another Board of Review; with a warning for a specified time limit (not to exceed two years). Programs can receive only one warning; warnings are appealable.
2. Continued accreditation is denied. Denials are appealable.

All Board decisions regarding accreditation are publicly disclosed.

A summary of the steps involved in the appeal process are as follows:

1. A program must notify the NLN of its intent to appeal within 10 days of the school's receipt of the written Board of Review recommendations.
2. An appeal panel is convened within 90 days of receipt of the school's notice of appeal; the school submits to the members of the appeal panel a written rationale in support of the appeal.
3. Two representatives of the program may attend the appeal and the dean/director may make a verbal presentation not to exceed 30 minutes.
4. The appeal panel can reaffirm, reject, or make another accreditation decision based on the review of the materials submitted to the appeal panel. Material that was not available to the program evaluators at the time of the site visit or to the Board of Review will not be reviewed by the appeal panel. The panel votes by ballot, and the chair of the appeal panel verbally informs the school representative who is present of the panel's decision. The written decision is then sent to the chief executive officer of the parent institution with a copy to the dean/director of the nursing unit. (For greater detail regarding the appeal process, see NLN, 1990, pp. 28-30.)

Monitoring and Evaluation Mechanisms

All components of the accreditation process are evaluated on an ongoing basis. Program evaluators are prepared in orientation workshops and appointed based upon positive peer evaluations. Updates are held at each council's annual meeting. Program evaluators are routinely evaluated by team members, by the administrators, faculties, and students of the programs they visit and by Board of Review members. Program evaluators must make at least three visits every four years and receive a majority of positive evaluations to be reappointed. Board members evaluate the work of other Board members, and the program representatives who attend the Board of Review meeting can evaluate the Board members present.

The Board of Review monitors programs that send letters regarding administrative changes in their programs or who notify the board of the closing of their programs (NLN, 1990, pp. 30-32).

Complaints about an accredited program are also handled by the Board when the following procedures are carried out (NLN, 1990, p. 32):

1. Letters of complaint must contain specific information about a violation in relation to specific criteria.
2. Letters must be signed.

3. Response to the complainant is written and forwarded to the administrator of the nursing unit.
4. A letter of inquiry relating to the complainant's comments is sent to the dean/director of the nursing unit. A response is expected to be returned to the NLN within 30 days.
5. The secretary of the Board of Review will decide, based upon the material returned, whether or not the information will be forwarded to the next scheduled Board of Review for that council.
6. The Board's action will be shared only with the school/program involved.

Strengths and Weaknesses of the Current Process

The current accreditation process has continually evolved and has been strengthened by the concerted efforts of the membership. Voluntary peer review and openness to change are two of the perceived strengths of the NLN accreditation process. The movement toward and leadership in developing outcome based criteria are examples of the results of peer review and ability to change. Since 1991 and the adoption of the outcomes-based criteria, the movement in accreditation has been toward an enabling model rather than reasserting a more rigid, prescriptive model. NLN accreditation sees this as a positive change, one that encourages programs to make innovations in nursing education. The resources and the faculty time required to undergo an accreditation visit may be viewed as a negative.

Proposed Modifications of Current Process

The accreditation process is continuously undergoing changes as its criteria and guidelines are reviewed in relation to the needs of all four educational councils, to the changes in the U. S. Department of Education regulations and guidelines, and changes in higher education. Based upon review by the Department of Education using 1994 rules and regulations, new approaches to program evaluator training will be developed to assure consistency in the application of standards. The structure of the NLN as a membership organization and its Division of Accreditation will be examined to assure the separate and independent status of accreditation. According to the Department of Education 1994 regulations, all accrediting bodies must institute methods for assuring reliability and validity of their accreditation standards/criteria.

Several other modifications are being considered for the near future. These modifications include but are not limited to:

- closer monitoring and training of program evaluators to assure greater consistency in program evaluators' performance and interpretation of criteria;
- a move toward common core criteria to be shared by all four educational councils, with inclusion of interpretive guidelines appropriate to each type of educational program; and
- use of Computerized Accreditation Self-Study (CASS), which offers new computerized programs for the development of the self-study and computerization of the entire accreditation process.

Impact of Accreditation Process

Accreditation has made an impact on nursing education in the United States. This impact is reflected in the incentives for seeking accreditation, the number of accredited and non-accredited programs, implications of non-accreditation, and measured improvements in nursing education resulting from the accreditation process.

Incentives for Accreditation

The incentives for NLN accreditation include voluntary peer review; acknowledgement by the profession of the quality of a program; assuring the public of the high quality and standards a program offers in nursing education; acceptance of an accredited program's graduates into the armed forces; eligibility for certain jobs; entrance to programs offering advanced nursing degrees; and eligibility for grants, scholarships, and fellowships.

Number of University Schools/Faculties Potentially Affected

The United States has a total of 1,493 basic RN programs, of which 1,186 are accredited and 307 are not (Nursing DataSource, 1994, Table 8, p. 37).

Number of Accredited and Non-Accredited University Schools/Faculties

Of the 507 identified baccalaureate programs, 480 are accredited and 27 are not; of the 857 identified associate degree programs, 578 are accredited and 279 are not; and of the 129 identified diploma programs, 128 are accredited and one is not. While the total number of licensed practical nursing programs is not available, there are cur-

rently 170 licensed practical nursing programs accredited (Nursing DataSource, 1994, Table 8, p. 37). In 1993, of 252 master's programs, 88.9 percent were NLN-accredited (Nursing DataSource, 1994, Table 3, p. 26).

Implications of Non-Accreditation

NLN accreditation is required or desired for selected governmental and private foundation funding, student grants, scholarships and fellowships, eligibility to enter any branch of the U.S. armed forces, governmental jobs such as in the Veterans Administration, and entrance into many advanced degree programs in nursing. Schools without NLN accreditation will have difficulty assuring the public that they offer a quality educational program that meets professional standards, that grant monies or jobs will be available to students upon graduation, or that graduates will be able to advance in the profession.

Measured Improvements in Nursing Education as a Result of Accreditation Process

Since mid-century, accreditation responsibilities have been centralized within the NLN, which has improved the quality of nursing education in the intervening years. Concerns in the earlier part of the century were centered upon faculty and student qualifications, relevant curricula and clinical experiences, adequate resources, and evaluation. Accreditation criteria also have focused on these areas. There is confidence today that if a school is NLN-accredited, evaluation in these areas has been conducted and that the school meets the majority of the appropriate criteria set by the nursing profession at the national level. Criteria include standards for faculty qualifications, require that student policies be clear and appropriate, and provide guidelines for curricula and clinical experiences. Accreditation criteria also determine adequacy of material resources such as facilities, budget and library, and incorporate an ongoing evaluation of the program.

Projections for Accreditation Process Over Next Ten Years

Status of Accreditation Process

It is anticipated that accreditation will continue over the next ten years. However, changes will occur as the accreditation process is not a rigid process but one that responds to changes within our society.

Recognition by Government

The National League for Nursing is currently recognized by the U.S. Department of Education as the accrediting agency for nursing education. NLN will hear the determination of it latest review by the Department of Education in June 1996.

Support from Universities

Higher education has been debating the merits and negative aspects of accreditation for the past few years and there are many divergent views. The need for specialized accreditation has been called into question and is often criticized as overly stringent. While universities generally have supported specialized accreditation, with decreasing federal and state funding and consequential downsizing, universities are increasingly scrutinizing the cost and benefits of regional and specialized accreditation.

Another perspective focuses on the current climate of skepticism about the quality of higher education and employers' need for assurances that graduates will possess the required knowledge and skills. This is particularly true for nursing, in view of the tumultuous changes occurring in health care. From this perspective, accreditation is supported as one approach to establishing national benchmarks for the profession.

Support from Schools/Faculties

Schools and faculties turn to specialized voluntary accreditation for guidance and for recognition of the quality of their programs. Agency members (schools) and individual members (faculty members) continue to support the work of accreditation through their voluntary participation in peer reviews and committees. The number of faculty and administrators who give generously of their time to the accreditation process is indicative of their support.

Proposed Modifications to Current Process

Modifications are currently in process as educational councils revise their criteria using the Core Criteria as the organizing framework and as the U.S. Department of Education reviews the NLN using the 1994 regulations. Each educational council will publish the new criteria by January 1997. Changes resulting from the Department of Education review are anticipated in the areas of orientation and training of program evaluators, structural changes in the NLN to assure the independence of accreditation from the membership organization, the conduct of site visits by program evaluators, the role of the Boards of Review, specific items to be included in criteria and poli-

cies, and the need for developing reliable and valid measures for all criteria. The Seventh Edition of *Policies and Procedures of Accreditation for Programs in Nursing Education* will be published in the summer of 1996.

The development of the Computerized Accreditation Self-Study (CASS) will require some modifications in the process. Developing a national database for nursing in the United States and its territories will be accomplished using the CASS model, the development of which was supported by a grant from the Helene Fuld Foundation. Through the use of the computerized self-study and an annual update of online information, trends in higher education can be documented, and information about programs, faculties and students can be gathered, analyzed, and used in research.

Computerization will change the daily operations of the accreditation process. For example, Boards of Review may be able to carry on their reviews on a regular basis, as opposed to convening two on-site meetings, using computers to review programs and to speak to other Board members. Program evaluators' reports may be addressed on the same computer-based system as the self-study report. Technology may provide other opportunities that are unforeseen at present.

International Interest in Accreditation Process

Type of Request for Information or Consultation

Administrators and faculty from a number of other countries have requested NLN accreditation materials, the *Policies and Procedures, Criteria and Guidelines*, and information about accreditation. NLN staff and individual members have reviewed programs outside of the United States and have served as educational consultants to those programs. In addition, international groups have come to the NLN to meet with the Director of Accreditation and with the directors of the four educational councils in order to understand the work of the organization and its effect on accreditation.

Level of Activity in International Arena

The numbers of international students are increasing in nursing education programs. The admission of these students or nurses from other countries is creating opportunities to learn about international nursing education and requiring exploration into admission policies for international students. The Council of Baccalaureate and Higher Degree Programs has an International Special Interest Group that meets at the annual meetings to discuss a number of international issues. As the world becomes a global community, the NLN anticipates participating in the international arena of educational standards development for nursing education and related activities.

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Accreditation of Nurse Anesthesia Education in the United States

Betty J. Horton, CRNA, MA, MSN
Council on Accreditation of Nurse Anesthesia Educational Programs

Executive Summary

Approval of nurse anesthesia educational programs in the United States is the responsibility of professional accreditation organizations rather than the federal government.

Key Stages in Development of the Accreditation Process

The National Association of Nurse Anesthetists, later renamed the American Association of Nurse Anesthetists (AANA), was founded in 1931 (Thatcher, 1953). Agatha Cobourg Hodgins, the founder, declared that education was her primary interest and saw a need to develop high-quality anesthesia educational programs for nurses. By 1942, the AANA had formed an Approval of Schools Committee that approved nurse anesthesia programs until it was replaced with the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) in 1975.

The creation of the COA was part of a major reorganization of the AANA that resulted in the establishment of autonomous councils for accreditation and certification (Gunn, 1990). The reorganization was necessary to comply with new requirements of the U.S. Department of Education (DOE). The impact of federal government requirements on the operation of the COA and other private accrediting agencies continues, as the Higher Education Act (HEA) is reauthorized every seven years. When the HEA was last reauthorized in 1992 and the regulations to implement the act were published in 1994, accrediting agencies were required to make significant changes in standards, policies, and procedures. The regulations attempted to link educational quality in an institution to how well its students repaid federal loans.

Summary of the Current Status of the Accreditation Process

Bylaws of AANA authorize the COA to operate as an independent fiscal and decision-making body that accredits nurse anesthesia programs. In addition, the COA is recognized by the secretary of the U.S. Department of Education (DOE, 1995) and the Commission on Recognition for Postsecondary Accreditation (CORPA, 1995) as the accrediting agency for nurse anesthesia programs that prepare graduates for entry-level practice at the certificate, baccalaureate, master's, and doctoral degree levels in the United States and its territories.

As an accrediting agency, the COA is responsible for establishing the standards, policies, and procedures for accreditation of nurse anesthesia programs and for making

accreditation decisions. There are six accreditation standards, each with numerous measurable criteria, including administrative policies and procedures, institutional support, curriculum and instruction, faculty, evaluation, and ethics (COA, 1994). These standards undergo periodic revision that includes extensive input from a broad community of interest.

Programs must complete written self-studies and undergo on-site visits from a review team that is selected by the COA. Accreditation decisions are based on how well programs comply with the standards. The maximum length of accreditation is six years.

Projections for the Accreditation Process Over the Next Ten Years

General support for accreditation in the United States is expected to continue. Accreditation policies and procedures will undergo periodic review to comply with the requirements of external agencies and in response to suggestions from the communities of interest. New federal rules and regulations will be written in 1997, when the HEA is next scheduled for reauthorization. The degree of change that will be needed to adapt to revised regulations cannot be predicted.

Specialized accreditation has been generally supported by academia. However, the cost of multiple accreditations is a growing concern. The time and expense to a university of seeking accreditation for the entire institution, as well as separate accreditation for a variety of specialized programs, can be significant.

The demand for nurse anesthetists is market driven, and the number of educational programs is the result of market forces. Currently, changes in the health care system are leading fewer physicians to select anesthesia as a specialty. If this trend continues, more certified registered nurse anesthetists may be needed to meet the need for anesthesia services in the United States. Logistically, the impact of an increased need for more CRNA's would result in the establishment of more programs and/or larger programs. As programs expand and become more complex, the accreditation process will have to adapt.

Conversely, the fact that managed health care makes it difficult for teaching hospitals to compete with non-teaching hospitals that do not support educational programs (Mercer, 1995) could lead to the funding of fewer programs.

History of Accreditation Process

Nurse anesthetists have been administering anesthesia in the United States for over 100 years.

Background to Establishment of the Accreditation Process

Key Factors

In 1877, Sister Mary Bernard was asked to assume the duties of administering anesthesia at St. Vincent's Hospital in Erie, Pennsylvania, becoming the first nurse anesthetist on record in the United States (Bankert, 1989). Formal training of nurse anesthetists soon followed, with the first school being established in Portland, Oregon in 1909. Thatcher (1953) reported that four schools had been established by the time World War I began.

In 1933, the newly-formed National Association of Nurse Anesthetists, later called the American Association of Nurse Anesthetists (AANA), expressed interest in creating mechanisms for accreditation and certification. However, such programs were not actually initiated until 1952, with support from the American Hospital Association. Information on 104 programs was published by the AANA in 1954 as the first official list of approved schools.

In 1955, the AANA was recognized as the accrediting agency for nurse anesthesia programs by the U.S. Department of Health, Education, and Welfare (later known as the U.S. Department of Education [DOE]). Its recognition was needed for veterans to use educational benefits from the government to obtain their anesthesia education (Gunn, 1990). In 1975, accreditation and DOE recognition were voluntarily transferred to the Council on Accreditation of Nurse Anesthesia Educational Programs (COA), which still retains responsibility for accreditation of nurse anesthesia programs as a fiscally and operationally autonomous council of the AANA. Members of the COA represent nurse anesthesia educators, nurse anesthesia practitioners, students, anesthesiologists, hospital administrators, university administrators, and the public (COA, 1994).

Key Organizations

AANA. Historically, the American Association of Nurse Anesthetists has been the key organization that influenced the approval of all nurse anesthesia programs in the United States. This professional organization initiated the accreditation program and transferred the responsibility to the COA. In cooperation with the AANA Education Committee, the COA has periodically revised the accreditation standards, most recently in November 1994.

Nurse anesthesia programs are located in hospitals and in a variety of graduate academic settings, including schools of health sciences and nursing. According to the AANA Education Committee (Annual Committee Reports of the AANA, 1989-1990), the diverse settings are designed to promote the movement of nurse anesthetists into graduate nursing education and other supportive disciplines. The COA is the only agency that accredits all types of nurse anesthesia programs in the United States. Programs that reside within schools of nursing can also choose to seek accreditation from the National League for Nursing (NLN).

DOE. The Secretary of the U.S. Department of Education (DOE) determines which accrediting agencies are considered to be reliable authorities regarding the quality of higher education programs (DOE, 1995). The recognition process is implemented through regulations of the Higher Education Act (HEA) that specify what is required for accrediting agencies to gain recognition. The regulations have a great deal of influence on the policies and procedures of the private accrediting agencies that are recognized by the DOE. Furthermore, recognition by the Secretary of Education is important to educational programs and universities because they must be accredited by at least one recognized agency to be eligible for federal funding.

CORPA. The Council on Postsecondary Accreditation (COPA) and a successor organization, the Commission on Recognition of Postsecondary Accreditation (CORPA), have also influenced the development of standards of accreditation and policies and procedures for numerous accrediting agencies in the United States. A decision to seek recognition from CORPA is voluntary, and receipt of recognition indicates that accreditation policies and procedures meet specific criteria (CORPA, 1995). The commission has no official connection with federal or state government.

ASPA. The Association of Specialized Professional Accreditors (ASPA) is an organization of approximately 40 accrediting agencies that was created in 1993 to meet the professional needs of specialized accreditation (ASPA, 1993) when that service was curtailed by the dissolution of COPA. The association has adopted a code of good practice and other guidelines for accrediting agencies. The COA, as a member of ASPA, voluntarily complies with these principles, which has a favorable impact on interaction between COA and accredited programs.

Establishment of the Accreditation Process

Approval of nurse anesthesia programs was an early objective of the professional organization.

Founding Organizations and Key Features

The AANA initiated the accreditation process for nurse anesthesia education programs more than 40 years ago. Graduates of accredited programs are eligible to write the certification examination to become certified registered nurse anesthetists (CRNA's). They administer more than half of the 26 million anesthetics given each year in the United States and are the sole anesthesia providers for a majority of anesthetics given in rural areas every year (DePaolis-Lutzo, 1995). Almost 27, 000 CRNA's live in the United States and 92 percent have voluntarily chosen to be members of the AANA.

Certified registered nurse anesthetists provide anesthesia services in the civilian and military sectors and practice in all types of settings. Their employment arrangements include hospitals, medical centers, ambulatory care centers, self-employment, and physician anesthesiologists, among others.

Stated Objectives

The purposes and objectives of the COA are stated in the bylaws (COA, 1995).

Its purposes are:

1. to advise, formulate, and/or adopt standards, guidelines, and criteria for the accreditation of nurse anesthesia educational programs, which are subject to review and comment by all constituencies that are significantly affected by them.
2. to accredit nurse anesthesia educational programs.

Its objectives are:

1. to foster continuing improvement in nurse anesthesia education as a basis for promoting quality nurse anesthesia services to the public.
2. to ensure the quality of nurse anesthesia educational programs through their evaluation in terms of their ability to meet program objectives and other criteria as established by the Council.
3. to stimulate and ensure the participation of the faculty of nurse anesthesia educational programs in the continuous process of evaluation and improvement of programs and their products.
4. to provide consultation and guidance, as required for initiating new nurse anesthesia educational programs or improving ongoing programs.

5. to encourage innovation in program design and/or experimental programs that are based on sound educational principles.
6. to promote individual student responsibility for continuing personal and professional growth, which includes continued licensure as a registered, professional nurse and continued certification as a nurse anesthetist.
7. to make available material to all who have or express a need for such information relative to the accreditation status of nurse anesthesia educational programs, their standards and guidelines, their accreditation policies and procedures, and the annual reports of the council.
8. to provide prospective students with an assurance of quality education in the selection of an accredited nurse anesthesia educational program.
9. to ensure responsiveness at both the program and accrediting agency levels to the public, students, and the community of interest within which nurse anesthesia education exists.

Initial Structure of the Accreditation Process

Nurse anesthetists took the initiative to ensure the quality of their educational programs over fifty years ago.

Key Organizations Involved in the Process

Firm plans for accreditation began with the establishment of an AANA Approval of Schools Committee and an advisory group in 1946 (Bankert, 1989). Approval for accreditation of nurse anesthesia programs was confirmed when AANA members adopted an increase in dues to support accreditation during the 1950 AANA annual meeting. The accreditation process finally became effective in 1952, with the stipulation that existing programs be given one year to comply with accreditation criteria. A decision also was made to require graduation from an accredited program as a prerequisite to writing the qualifying examination for AANA membership.

On January 19, 1952, accreditation of nurse anesthesia programs officially began (Thatcher, 1953). The responsibility was delegated to the Approval of Schools Committee of the AANA that continued to exist until the accreditation process was reconfigured during the 1970's. The reconfiguration was undertaken in response to a change in the recognition criteria published by the U.S. Secretary of Education. One reason for the change in criteria was to ensure that an accrediting agency used an impartial decision-making process. The AANA complied with this requirement by developing an autonomous council, thereby eliminating any potential that the profession would influence accreditation decisions or the numbers of practitioners in the field.

On December 7, 1974, the AANA Board of Directors adopted a motion to create the COA with 11 members representing the public, students, hospital administration, anesthesiologists, the AANA Education Committee, and CRNA's (AANA, 1974). The AANA bylaws (AANA, 1975) confirm this original structure. Initially, the COA was composed of members of an ad hoc committee of the AANA. They served three-year terms and were eventually replaced through election by COA members. It was not until 1995 that a university representative was added to the membership in response to the movement of programs into graduate degree frameworks.

The 1975 bylaws also stated two reasons for the existence of the COA: to develop and adopt standards, guidelines, and criteria for accreditation that were subject to review and comment by the AANA Board of Directors, and to accredit nurse anesthesia programs.

Levels of Authority and Control

A bylaw change by the AANA created the COA for the express purpose of accrediting nurse anesthesia programs. This authority was unsuccessfully challenged by a group of anesthesiologists in 1975 when they petitioned the U.S. Secretary of Education to gain control of the accreditation and education of nurse anesthetists (Bankert, 1989). The outcome of this challenge was that nurse anesthetists maintained control of accreditation and education, but they added anesthesiologists as on-site reviewers and elected additional anesthesiologists as members of the COA.

Current Status of Accreditation Process

Description of the Current Accreditation Process

Accreditation serves to improve education and practice by requiring accredited programs to comply with established standards. Programmatic self-study, on-site reviews, and periodic assessment by the COA are key elements in the process. Programs that demonstrate successful compliance with accreditation standards are granted public recognition by the COA (COA, 1990).

Steps in the Process

Only programs that prepare graduates for entry into anesthesia practice are eligible for accreditation. The COA does not approve programs that are established for the purpose of admitting previously certified registered nurse anesthetists or non-certified graduates of accredited programs.

An applicant program must comply with any local or state legal requirements governing the operation of an educational program and/or authorizing the credential to be awarded. Additional accreditation by an accrediting agency for universities or other accrediting agencies is not required for any conducting institution, including university-controlled programs or single-purpose institutions.

Application for a new program includes a letter of intent from the chief executive officer of the conducting institution, a written self-study, and the payment of an application fee. An on-site visit is conducted by a team of two or three reviewers, who assess the proposed program's ability to meet accreditation standards. The program that is applying is given the opportunity to respond to a written summary report of the on-site visit and to meet personally with COA members. A decision is then made by the COA to grant accreditation, defer action, or deny accreditation.

Students are not to be admitted before the awarding of accreditation to a program. A second on-site visit is conducted after graduation of the first class of students and after receiving the results of the certification examination administered by the AANA Council on Certification. The timing of the second visit allows the program to demonstrate how successful it has been in achieving the educational outcomes that were proposed when it was planned. The program again is given the opportunity to interact with the COA before an accreditation decision. A decision can be made for accreditation, deferral of action, probation, or revocation of accreditation.

Time Frame and Milestones

Established programs are routinely notified to initiate a self-study in preparation for an on-site visit. The request is made every six years, or sooner if the length of accreditation previously awarded by the COA was shorter. A summary report of the on-site visit is written by a review team, and the program is asked to respond. An invitation is extended to appear before the COA. Action on accreditation can be deferred, accreditation can be continued, or the program can be placed on probation or have its accreditation revoked.

Authorities and Structures

The COA was given authority to operate through a change in the AANA bylaws (AANA, 1975). Its authority, structure, and current operation are governed by COA bylaws (COA, 1995). Actions that can be taken by the COA are published in the *Accreditation Policies and Procedures Manual* (COA, 1990).

There are 11 members of the COA, including three CRNA educators, two CRNA practitioners, the chair of the AANA Education Committee, one anesthesiologist, one hospital administrator, one university administrator, one student, and one public member. The chair is always a CRNA, and the majority of members are CRNA's. Members are solicited from the AANA Board of Directors and from the communities of interest before they are elected by the COA to a three year term. Any member is eligible to be elected to a second three year term except the AANA Education Committee Chairman and the student, who each serve one year terms.

During a COA meeting, programs are divided among work groups composed of COA members. Each work group makes independent assessments of a program's compliance with accreditation standards. A report is then presented to the full council with a recommendation for accreditation status; final decisions are made by all COA members.

Decision Process

Accreditation decisions are considered to be final at the time they are made. Adverse accreditation decisions become effective pending the outcome of the reconsideration and appeal processes if invoked by the program. Final accreditation decisions are publicly disclosed. The actions that can be taken by the COA include the following:

1. Accreditation can be granted for a new program after a capability review that takes about one year to complete. Accreditation is effective on the date it is granted by the COA and is not retroactive. A second self-study and on-site visit are conducted after the graduation of the first class of students to provide the program and the COA with an opportunity to assess how successful the program was in achieving its stated outcomes. Progress reports may be requested during an accreditation cycle.

Other actions that can be taken when new programs are being considered include:

1. A decision on accreditation of a new program may be deferred by the COA until its next regularly scheduled meeting. Deferral of action is taken when there is insufficient information to make a decision during COA deliberations. Deferral of action gives the program that is applying more time to meet the requirements as stated in the *Standards for Accreditation of Nurse Anesthesia Educational Programs* (COA, 1994).
2. Accreditation may be denied an applicant program that fails to demonstrate the ability to meet accredita-

tion requirements. Denial of accreditation can be appealed after a request is made for reconsideration of the decision.

Continued accreditation for established programs can be granted for a maximum of six years, with or without progress reports. Annual reports that address changes within the program and provide information to the COA for inclusion in a computerized database are required of all accredited programs.

Other actions that can be taken include:

1. Requesting a program to show cause why it should not be placed on probation or have its accreditation revoked. The program must respond to a show cause letter by a specified date to allow time for the COA to review the response before making an accreditation decision. A show cause action is not an adverse accreditation decision, but it constitutes a warning to a program and therefore cannot be appealed.
2. An accredited program can be put on probation and prohibited from admitting students for a period not to exceed one year. Before that time, the program can request an on-site visit for the purpose of lifting the probation.
3. Continued accreditation may be revoked when serious deficiencies are identified that cannot be corrected in the foreseeable future. The date of revocation is set to permit graduation of students who have been enrolled in the program for more than one year.

Appeal Body and Process

Nurse anesthesia programs must request that the COA reconsider an adverse accreditation decision before appealing the decision. If an adverse decision is upheld by the COA upon reconsideration, the program can appeal. Adverse decisions include denial of accreditation, probation, and revocation of accreditation.

An autonomous Council for Public Interest in Anesthesia (CPIA) serves as the appeal body. The authority of the appeal body is established through the AANA bylaws (AANH, 1995) and is identified in the COA bylaws (COA, 1995). Membership in the CPIA is multidisciplinary, with significant representation of the public; members of the CPIA are elected by that council.

All material that is available to the COA at the time of the adverse decision and during the reconsideration process is made available to the CPIA and the program for use in the appeal process. The CPIA makes a decision to affirm or annul the adverse accreditation action and notifies the program and COA of its decision. An adverse accreditation action that is affirmed becomes effective immediately upon receipt of notice by the program. In such an event, no new students can be admitted until accreditation status has been regained. If the adverse accreditation decision is annulled, accreditation of the program is continued.

The appeal procedure is the property of the CPIA, the appeal body for accreditation. The procedure is published in the *Accreditation Policies and Procedures Manual* (COA, 1990) for easy access by the community of interest.

An overview of the appeal process is listed below:

1. A program must notify the COA that the adverse accreditation is being appealed within 30 days after receiving official notification.
2. The adverse accreditation decision does not take effect until after the appeal hearing and then only if the decision of the COA is affirmed.
3. The COA forwards material used in reaching the accreditation decision and during the reconsideration process to the CPIA along with the program's letter of intent to appeal. The program also has the right to the same material.
4. The CPIA schedules a date for the appeal hearing, which is closed to the public.
5. Representatives of the program and advisors can attend the appeal hearing and make a presentation, as can COA representatives.
6. New information cannot be considered during an appeal hearing.
7. A decision is made by the CPIA to affirm or annul the adverse accreditation decision, and the program and COA are notified accordingly.
8. If the adverse accreditation decision is affirmed, the program is notified that the decision is in effect. If the adverse accreditation decision is annulled, accreditation of the program that has continued throughout the appeal proceeding remains in effect.

Monitoring and Evaluation Mechanisms

Accredited programs are monitored and evaluated through annual reports, progress reports, evaluations and by investigation of written and signed complaints that allege violations of accreditation standards. For example, programs that have undergone major programmatic changes are monitored through progress reports, annual reports, and student or faculty evaluations, as indicated.

Complaints about an accredited program receive serious attention, in accordance with COA policy. The identity of a complainant will be kept confidential if requested,

but anonymous complaints are not considered. A complainant is required to specifically identify the standards and criteria that the program has allegedly violated. Details about the complaint are provided to the program, which is given an opportunity to respond. The COA will then consider the complaint at a regularly scheduled meeting. A mechanism exists for immediate action if there are questions regarding safety to patients, faculty, students, or others. The COA's final action on the complaint will be shared with the program administration and the complainant.

Several methods also are used to monitor the performance of the COA. First, the program directors and faculty are invited to complete written evaluations of the reviewers after an on-site visit. A critique of the summary report of the visit is also provided by the staff analysts and members of the COA. Feedback from the evaluations is provided to the reviewers. Complaints against the COA are referred to the chair for investigation and presented to COA members for action. The complainant receives a written response from the COA regarding action on the complaint.

Strengths and Weaknesses of the Current Accreditation Process

The COA continually assesses the strengths and weaknesses of accreditation in an effort to improve the process.

Perceived Strengths of the Process

Accreditation provides a reasonable assurance to prospective students and the public that an accredited program has met specific quality standards. Students can have confidence that their graduation from such a program meets an important eligibility requirement for writing the certification examination. Certification as a CRNA is commonly believed to be almost a universal requirement for employment. Approximately 40 states require that to use the title of nurse anesthetist or to practice as one, the nurse must have graduated from an accredited program (M. Tobin, personal communication, September 18, 1995). The accreditation standards and criteria also encourage programs to participate in a continual self-evaluation process that examines educational outcomes and results in improvement of the quality of the program.

Perceived Weakness of the Process

An inter-rater reliability exercise using reports of on-site reviewers was completed by an external consultant several years ago. However, a systematic process for assessing the validity, reliability, and relevancy of accreditation standards is needed. A policy and procedure has been written, which was initiated in May 1995 and will be fully implemented in 1996.

Proposed Modifications to the Current Process

Training of on-site reviewers always has been an area that could be improved to increase the reliability of on-site evaluations. In addition, a change in the method of entering data into the computer database from the annual reports is needed to incorporate the use of document scanners.

Impact of the Accreditation Process

Attaining accreditation for a nurse anesthesia program is very important in the United States.

Incentives for Seeking Accreditation

The federal government requires programs to be accredited by agencies that are recognized by the U.S. Department of Education so that they can qualify for participation in federal loan programs. Non-governmental loans and scholarships also frequently require enrollment in accredited programs. Additionally, accreditation is believed to offer reasonable assurances of a quality educational program.

Number of Programs and Faculty Potentially Affected

The COA accredits 91 nurse anesthesia educational programs that use more than 500 clinical sites with an enrollment of 2017 students (S. Caulk, personal communication, September 22, 1995). There are 3,986 CRNA's and anesthesiologists involved in the clinical education of nurse anesthesia students (COA, 1994, August). This figure is comparable to the number of clinical faculty involved in teaching physicians to become anesthesiologists (Jonas & Barzanski, 1993). Every program is required to have a CRNA director and a CRNA assistant director. The selection of other faculty is at the discretion of the program, with the exception of clinical instructors, who must be CRNA's or anesthesiologists.

The only non-accredited program within the geographical scope of the COA is currently undergoing a capability review. Educational programs that train nurses to administer anesthesia exist in other countries, but they have not expressed interest in being reviewed by the COA. Furthermore, no mechanism exists on an international

basis for this type of activity in nurse anesthesia education. Such a mechanism has been initiated by several other United States - based accrediting agencies (Maudlin-Jeronimo, 1992).

Implications of Non-Accreditation

Graduation from a non-accredited program does not qualify the graduate to write the certification examination to become a CRNA. Because it is common knowledge that certification is required by almost every employer, civilian or military, the implications of graduating from a non-accredited program are very serious. The lack of accreditation also would prevent students from qualifying for federal student loans, and hospitals from receiving money from Medicare to defray the cost of clinical education.

Measured Improvement Resulting from Accreditation

The education of nurse anesthetists has improved since the beginning of accreditation, as evidenced by the evolution from on-the-job training to graduate-level education, with more than 90 percent of programs offering master's degrees. Accreditation requirements have resulted in a change from sporadic classroom instruction to regularly scheduled classes. Faculty qualifications also have been improved by accreditation requirements and active clinical instruction has been encouraged as a replacement for passive supervision. More recently, emphasis has been placed on evaluating the success of programs by their achievement of educational outcomes as part of a plan to improve the educational process.

Accreditation has also served to standardize the basic educational requirements of nurse anesthetists. Importantly, accreditation requirements have consistently increased the quality of programs throughout the years. This has been accomplished through the communities of interest that have critiqued accreditation standards and supported changes that were aimed at meeting the needs of students for entry into practice.

Projections for the Accreditation Process Over the Next Ten Years

Accreditation by private agencies is expected to continue in the foreseeable future.

Status of Accreditation Process

Recognition by Government

General support for accreditation in the United States is expected to continue. Accreditation policies and procedures will undergo periodic review to comply with the DOE and CORPA requirements and in response to suggestions from the communities of interest. New federal rules and regulations will be written when the HEA is reauthorized in 1997.

Currently, an institution may be accredited by several accrediting agencies, while only one accreditation is required for an institution to participate in most federal funding programs. This link between accreditation and federal funding is not related to the quality of an accrediting agency. Furthermore, an accrediting agency does not need to be recognized by the Secretary of Education in order to operate. However, limiting the number of accrediting agencies that can receive recognition from the federal government will result in the Secretary overseeing fewer agencies.

Support from Universities

Specialized accreditation has been generally supported by academia, as demonstrated by the number of accredited educational programs that reside within universities. However, the cost of multiple accreditations is becoming a more significant factor than in the past. The combination of time and expense for a university that is seeking accreditation for the entire institution as well as separate accreditation for a variety of specialized programs can be significant.

Support from Schools/Faculties

In a survey of nurse anesthesia programs conducted by Booth (1993), widespread support was demonstrated for accreditation by the COA. Support is also indicated by the willingness of programs to pay annual dues and participate in educational conferences sponsored by the COA.

Proposed and Anticipated Modifications to the Current Process

Periodic changes in recognition criteria from the DOE and CORPA are the reasons for the modification of the accreditation process in most instances. The following modifications recently have been completed or are in the process of being changed:

- The *Standards for Accreditation of Nurse Anesthesia Educational Programs* were revised in 1994 to comply with changes in recognition criteria from the DOE and CORPA.
- The *Accreditation Policies and Procedures Manual* is currently under revision to comply with changes in recognition criteria from the DOE and CORPA.
- The *Reviewers' Manual* will be revised in the next two years to update the contents and provide useful guidelines for on-site reviewers.

The demand for nurse anesthesia educational programs is market driven, and manpower shortages or excesses can influence the level of accreditation activity. Currently, changes in the health care system are resulting in fewer physicians selecting the specialty of anesthesia. If this trend continues, more CRNA's may be needed to meet the needs of anesthesia services in the United States. The impact of an increased need for CRNA's would logically result in the establishment of more and/or larger programs. As programs expand and become more complex, the accreditation process must adapt. Conversely, the financial support for programs will be scrutinized, because managed health care makes it difficult for teaching hospitals to compete with non-teaching hospitals that do not incur the expense of educational programs (Mercer, 1995). This factor could lead to the funding of fewer programs.

International Interest in the Approval Process

International interest in the practice of nurse anesthesia is increasing.

Type of Request for Information or Consultation.

The majority of international inquiries come from individuals who have practiced anesthesia in another country and want to practice in the United States. Each inquiry receives a written response that includes suggestions regarding whom to contact about meeting requirements to practice as a nurse in the United States and to gain admittance to an accredited nurse anesthesia program. A few representatives from other countries also have either visited the COA or expressed interest in future visits. Accreditation materials are provided upon request.

Level of Activity in the International Arena

One objective of the AANA is to serve as a worldwide resource regarding nurse anesthesia (Present highlights of strategic plan, 1995). In September 1995, the AANA agreed to provide an office for the executive director of the International Federation of Nurse Anesthetists (IFNA) at its headquarters in Park Ridge, Illinois.

The International Federation of Nurse Anesthetists was founded in June 1989 with 11 countries as charter members (Caulk, 1992). Saint Gallen, Switzerland, was chosen as the official headquarters for the organization where it remains today. There are now 20 countries as members of IFNA that represent over 30,000 nurse anesthetists worldwide. English, French, and German are currently spoken at committee meetings. Spanish may be considered if the current application from the Mexican organization is approved.

In 1994, the COA was the recipient of a three year grant from the DOE Fund for the Improvement of Postsecondary Education (FIPSE) to study educational requirements and barriers to mobility of nurse anesthetists throughout North America. A faculty exchange between the anesthesia program in Mexico and programs in the United States will be initiated in 1996 as part of the demonstration project. An advisory committee and coalition of interested individuals from Canada, Mexico, and the United States are involved as participants or observers in the project. Lois Frels, PhD, is the project director, and Betty Horton, CRNA, MA, MSN is the associate director.

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Similarities and Differences in Approval of Nursing Education Programs in Canada, Mexico and the United States

Part Two has described in detail the methods of approval of nursing education programs in Canada, Mexico and the United States. Outlined below are the major aspects of the approval process, and how each country contrasts in its approach.

Aspects of Process	Canada	Mexico	United States
Existence of legal bases that support approval at the national and state levels	Provincial legislation delegates the approval of nursing education programs to self-regulating nursing bodies in most provinces	Exist at the national and state levels	State legislation delegates the approval of nursing education programs to state boards
Organizations responsible for approval	In most provinces, professional regulatory bodies	School Council and the Higher Education Institution Council to which the nursing school belongs	Generally, boards of nursing
Election or appointment of regulatory positions	Generally, nurse positions on regulatory body are elected and public representative positions are appointed	Elected positions in accordance with institutional standards	Generally appointed
Existence of training programs for regulatory body members	Yes	No specific program	Yes
Institutions that define the standards for approval	Self-regulating nursing bodies	The SEP and Higher Education Institutions	Generally, boards of nursing
Objectives of approval	Protection of the public	Improvement of education quality and its impact on meeting social needs	Protection of the health, safety and welfare of the public
Existence of standards for approval	Yes	Yes	Yes
Elements to evaluate for approval	Generally include structure, process, resources and outcomes	Generally include structure, process and resources but few elements related to outcomes.	Generally include structure, process, resources and outcomes
Existence of processes for approval	Yes	Yes	Yes
Existence of methods for collecting information	Yes	Yes	Yes
Importance of outcomes of educational programs	Yes	Yes	Yes
Criteria for evaluation, for approval	Yes	Yes	Yes
Education model/approach at national, provincial, regional or institutional level	Institutional level	Institutional level. National level, with general policies of the country	Institutional level

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Aspects of Process	Canada	Mexico	United States
Focus on contents of the educational program	Yes	Yes	Yes
Integration of theory and practice in the curriculum	Yes	Yes	Yes
Integration in the curriculum of nursing and non-nursing courses	Yes	Yes, including physical, social and cultural activities	Yes
Evaluation of approval standards to verify that they are consistent with the needs for health care and professional development	Yes	Yes	Yes
Consideration of requirements for student enrollment, progression and graduation	Yes	Yes	Yes
Evaluation plans for the educational programs, students and faculty	Yes	Yes	Yes
Evaluate support for the educational programs (finances, organization, resources, etc.)	Yes	Yes	Yes
Support from higher education institutions and authorities involved in approval	Yes	Yes	Yes
Approval is mandatory	Yes	Yes	Yes
Frequency of approval	Initial and approximately every 5 years	Initial and annually in most schools	Initial and on a routine basis (every 4-5 years)
Document given upon approval	Yes	Yes	Yes
Fee for approval	No	Schools of the Higher Education Institutions are not charged a fee; schools recognized by Higher Education Institutions pay a fee	No
Recommendations and measures for educational programs when approval is denied	Yes	Yes	Yes
Involvement of public in regulatory bodies	Yes	No	Yes

Similarities and Differences in Accreditation of Nursing Education Programs in Canada, Mexico and the United States

In combination with the description of the approval process, Part Two has also illustrated the accreditation process for nursing education programs. Following are similarities and differences in the accreditation processes of Canada, Mexico and the United States.

Aspects of Process	Canada	Mexico	United States
Existence of legal bases that support accreditation at the national and state levels	No	Existence of legal basis for the evaluation stage	Yes, Federal Department of Education and some state legislation
Organizations responsible for accreditation	Canadian Association of University Schools of Nursing	Not existing	Council on Accreditation of Nurse Anesthesia Educational Programs, American College of Nurse Midwives, National League for Nursing
Election or appointment of accreditation positions	Appointed by members of CAUSN from membership	Not existing	Elected by council members
Existence of training programs for members of accreditation bodies	Yes	Training in evaluation	Yes
Organizations that define the standards for accreditation	CAUSN	Not existing	NLN, COA and ACNM
Objectives of accreditation	Excellence and quality	In planning for excellence and quality	Excellence and quality
Existence of accreditation standards	Yes	General standards for evaluation exist; standards for accreditation are being planned	Yes
Elements to evaluate for accreditation	Relevance, relatedness, accountability and uniqueness	Foundations, objectives, profiles, organization, content, methodology, human and physical resources and program evaluation	Structure and governance, material resources, faculty, students, curriculum and evaluation
Existence of accreditation processes	Yes	In planning stage	Yes
Existence of methods for collecting information	Yes	In some higher education institutions	Yes
Importance of outcomes of educational programs	Yes	Evaluation is conducted in most schools	Yes
Education model/approach at national, provincial, regional or institutional level	Institutional	Institutional	Institutional
Focus on contents of the educational program	Yes	Yes, in evaluation	Yes

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Aspects of Process	Canada	Mexico	United States
Integration of theory and practice in the curriculum	Yes, including clinical practice	The contents of the curriculum are integrated throughout the studies	Yes, including clinical practice
Integration in the curriculum of nursing and non-nursing courses	Yes	Yes	Yes
Evaluation of accreditation standards to verify that they are consistent with the needs for health care and professional development	Yes	Yes	Yes
Consideration of requirements for student enrollment, progression and graduation	Yes	Considered in accreditation planning	Yes
Consideration of the evaluation plans for the educational programs, students and faculty	Yes	Considered in accreditation planning	Yes
Evaluate support for the educational programs (finances, organization, resources, etc.)	Yes	Considered in accreditation planning	Yes
Support from higher institutions and authorities involved in accreditation	Yes	Partial support (without financing)	Yes
Accreditation is voluntary	Yes	Planned as voluntary	Yes
Frequency of accreditation	Initial is 3 to 7 years, depending on period of accreditation; continued is same	No consensus on frequency yet	Initial is 5 years and continued is 8 years for NLN; Initial is 3 years and continued is 6 years for COA; Initial is 5 years and continued is 8 years for ACNM.
Document given upon accreditation	Yes	Planned	Yes
Fee for accreditation	Annual fee plus fee for visit	Planned	Annual fee plus fee for visit
Recommendations and measures for educational programs when accreditation is denied or conditional	Yes	Considered in accreditation planning	Yes
Involvement of public in accreditation bodies	Yes	Under consideration	Yes

Recommendations

Nursing Education Program Approval and Accreditation in Canada, Mexico and the United States

In consideration of the similarities and differences in the approval and accreditation processes, the following recommendations are made to further improve the quality and balance of nursing education programs in North America.

1. It is recommended that a collaborative trilateral process be pursued to conduct a more detailed comparative analysis in each country of the standards that guide the development of excellence in nursing education through accreditation programs and national nursing education standards.

2. It is recommended that strategies be established to decrease the differences among the three countries in terms of accreditation of the quality of educational programs, but with full respect for the sovereignty of each of the participating countries.

3. It is recommended to strengthen the exchange of information among the bodies in charge of the approval and accreditation processes in each country.

Part Three

Licensure/Registration of Nurses and Standards of Practice in Canada, Mexico and the United States

In this section, licensure/registration processes and standards of nursing practice in the three North American countries are examined and compared. Licensure/registration are processes by which a legally-authorized entity determines that an individual who meets minimum standards may engage in a given profession or use a particular title. It also denotes to the public that the individual has the competence needed to provide for the public's protection and is accountable for his or her practice. The term "standards of practice" refers to an agreed upon level of performance in nursing practice. Regulatory standards describe the minimum acceptable levels of nursing practice that serve as a guide to evaluate the safety and effectiveness of nursing practice. Professional standards, which differ from and may exceed regulatory standards, also exist. A fundamental understanding of these processes across borders is a necessary prerequisite for working toward mutually acceptable standards.

Following individual chapters on licensure/registration and standards of practice for nursing in Canada, Mexico and the United States, similarities and differences among the countries are summarized. Part Three closes with a section on "Opportunities and Recommendations", which identifies 1) important opportunities for mutual learning and possible action regarding licensure/registration and standards of practice, and 2) key recommendations synthesized from the identified opportunities.

Licensure/Registration of Nurses and Standards of Practice in Canada

Elisabeth Scarff, LL.B.
College of Nurses of Ontario

Executive Summary

Geographically, Canada is the second largest country in the world and has a population of approximately 29.6 million. Its two official languages are English and French, and it has an official policy of multiculturalism. It also has a large aboriginal population. Canada is a federal state, with governing power distributed between the central (federal) government, and the provincial/territorial governments. Matters that have not been explicitly assigned to the provinces/territories in the *Constitution Acts* are matters of federal jurisdiction. The authority to regulate professions, including health professions, is provincial/territorial.

Canada has a publicly funded, universal health care system. Constitutionally, health issues are in the jurisdiction of the provincial/territorial governments. However, the federal government has exercised considerable indirect control through its fiscal power and the provisions of the *Canada Health Act*, which set out the principles of federal funding. These are public administration, comprehensiveness, universality, portability, and accessibility. Fiscal constraints have put stress on the system, and as federal contributions to the provincial/territorial health budgets decline, the universal nature of the Canadian health care system is being challenged.

All provinces regulate registered nurses (RN's) and practical nurses' (PN's). Four provinces also regulate registered psychiatric nurses. A regulatory model based on the provincial/territorial governments delegating the right of self-regulation to the provincial/territorial nursing association has strong historical roots in Canada. Today, regulatory authority is set out in the provincial/territorial nursing act and all provinces/territories, except Ontario, continue to delegate the regulatory authority to the provincial/territorial nursing association. In Ontario, the professional association and regulatory functions have been separated. Most provinces/territories regulate RN's and PN's separately.

Each nursing regulatory body sets the eligibility criteria for registration/licensure, establishes the standards of practice for the profession (including standards relating to ethics and conduct), is responsible for monitoring the continuing competence of members, investigates complaints about members and disciplines members for breaches of nursing standards. In the majority of provinces/territories, the regulatory body is also authorized to review and approve the education program standards.

The core purpose of nursing regulation is protection of the public. The right of self-regulation is subject to accountability to the government and the public regarding the exercise of that right. Methods of demonstrating

accountability vary, but generally include submission of an annual report to the government, and the inclusion of government-appointed members on the governing board or council. In all cases, the majority of members of the governing board or council of the nursing regulatory body are members of the profession.

In 1994, there were approximately three RN's for every PN (approximately 264,900 RN's and 82,250 PN's). Over 88 percent of these were employed. Two-thirds of the population of Canada reside in Ontario and Quebec, as do two-thirds of the RN's and PN's.

While criteria for registration/licensure are established independently by the province/territory, certain basic requirements are common across the country. These include graduation from an approved nursing program, successful completion of the national registration examination, evidence of recent practice or study, proficiency in English or French, evidence of good character and payment of a prescribed fee. PN's in Quebec do not write the national examination. Approved nursing programs for RN's are either a five or six academic semester diploma nursing program or an eight academic semester university baccalaureate nursing program. RN's take the same national examination whether they have diploma or baccalaureate preparation. PN programs are a two or three academic semester practical nurse program. The national registration examination is prepared by the Canadian Nurses Association Testing Services. Individual provinces/territories may impose additional criteria.

Nurses moving from one jurisdiction in Canada to another are required to meet the entry requirements of the new jurisdiction. Mobility within the country is facilitated by the common national examination, and the agreement among the regulatory bodies (subject to some restricted variations) to treat approved nursing programs in other Canadian jurisdictions as equivalent to the provincial/territorial approved programs. Nurses from outside the country must meet all the entry requirements of the province/territory; equivalency of out-of-country nursing programs is usually assessed by the regulatory body.

Nurses are personally accountable for meeting the standards established or recognized by the regulatory body. These include general professional standards, nursing standards, ethical standards and direct care standards. They also include indirect standards, such as the Criminal Code, human rights acts, and professional standards that are widely understood and accepted in the profession.

Complaints that a nurse has acted incompetently or has breached a standard may be made by anyone, including the patient, the patient's family, colleagues and employers. Procedures and time frames regarding the process of a complaint are generally found in the nursing legislation, supplemented by any legislation relating to rules of natural justice and the conduct of administrative tribunals. Formal complaints are investigated and reviewed by an independent committee, and may be referred on for an adjudicative hearing by another independent committee. Sanctions can vary. In general, all regulatory bodies can impose terms, conditions or limitations on a member's certificate/license. The ultimate sanction is permanent revocation of the certificate/license.

Economic constraints have led to significant cuts, restructuring, rationalization and reassessment of federal and provincial/territorial social and health programs, policies and health care delivery models. Reassessments of which health providers can most cost effectively provide which services, and whether they need to be regulated providers are widespread. The role of regulatory bodies (e.g., to ensure patient safety, access to care, and the quality of nursing care) in decision-making regarding these issues is an area of concern. Other challenges facing nursing regulation include strong public demands for demonstrated accountability for the exercise of regulatory authority, stronger expectations of regulatory mechanisms that ensure continuing competence of nurses, controversy about whether a baccalaureate should be the minimum education preparation for RN's, and the regulatory role in regulating nursing specialties and/or advanced practice.

Overview of Factors That Have Shaped Licensure/Registration in Canada

Canada is a country of vast size, characterized by regional distinctions, diverse cultural composition, and English/French linguistic duality. Each of these factors has contributed to the distinctiveness of Canadian nursing and Canada's regulatory approach. A look at Canada's political structure and social history will contribute to an understanding of structures and trends in Canadian nursing regulation.

Form of Government

Political Structure

In 1867, the British provinces of Canada (then composed of Ontario and Quebec), Nova Scotia and New Brunswick established a federal union known as Canada. Other provinces in British North America joined in subsequent years, the most recent being Newfoundland, which joined in 1949.

Today, Canada is comprised of ten provinces and two territories. Its political structure both reflects and reinforces its natural regionalism. Canada is a federal state and its system of government is based on the British parliamentary model modified by a division of powers between the central, federal government and the regional (provincial and territorial) governments.

The distribution of authority between the federal and provincial/territorial governments is set out in Canada's *Constitution Acts, 1867 to 1982*. Each level has specific powers to make laws in a defined sphere of authority. One of the characteristics of the distribution of power under the *Constitution Acts* is that residual authority, i.e., power that has not been specifically allocated to the provinces, lies with the federal government, which has a general authority to legislate for the "peace, order and good government of Canada" with respect to all matters which have not been given exclusively to the provinces.

The *Constitution Acts* also ensure rights to education in either English or French, and in 1981, entrenched the *Canadian Charter of Rights and Freedoms* as part of the Canadian Constitution.

Canada's head of state is the Queen of Canada (who is also the Queen of England) through her representative, the Governor General. There are three branches of government: the legislative branch, the executive branch, and the judiciary or courts. The federal legislative branch (Parliament) consists of the Governor General and a two-chamber legislature. The position of the Governor General is largely ceremonial. The House of Commons (or lower house) is made up of elected Members of Parliament. The members of the Senate (or Upper House) are Senators who are appointed by the Governor General on the recommendation of the Prime Minister and serve until age 75. The authority of the Senate is limited, and the primary legislative authority lies with the House of Commons. The leader of the political party that wins the most seats in the House of Commons is the Prime Minister of Canada. The timing of federal elections can vary, but they must be held no more than five years since the previous election.

Reflecting the parliamentary model, there is not a strict separation of the legislative and executive branches. The federal executive branch is comprised essentially of the Governor General, the Prime Minister and the members of the Cabinet, who are selected from members sitting in Parliament.

Roots of Regulatory Approach

Authority to Regulate: Under the *Constitution Acts*, property and civil rights, as well as health and education, are matters of provincial jurisdiction. The regulation of occupations and professions, including health professions, falls within these rights. Regulation of nursing, therefore, is found in provincial or territorial legislation.

Basic Purpose: The basic premise of nursing legislation in Canada has been protection of the public interest. In New Brunswick, where regulatory legislation for nursing was first passed in 1916, the explicit legislative purpose was the establishment of a standard of qualifications "for the protection of the public". The importance and influence of this public protection mandate on the development of Canada's regulatory approach is clearly evident in contemporary registration acts and mission statements of the regulatory bodies.

The Registration Model: For the most part, nursing regulation in Canada has its historical roots in the regulatory model of registration, which restricted the use of titles such as Registered Nurse (RN), Practical Nurse (PN) and Registered Psychiatric Nurse[2] to those who are registered. Under this model, individuals who are not registered cannot claim to practice nursing, use the title or hold themselves out to be registered. This model differs from a licensure model, which gives a profession an exclusive scope of practice and prohibits someone without a license from doing anything within that exclusive scope. Some provinces use the registration model, but call the nursing certificate a "license".

Principle of Self-Regulation: An historical feature of nursing regulation in Canada is that it is based on a model of self-regulation. The provincial and territorial governments have delegated regulatory authority to the nursing profession through legislation. This is often referred to as the privilege of self-regulation; that is, authorizing the members of the profession to establish and enforce the standards governing the profession.

This authority is accompanied by specified conditions set out in the provincial or territorial nursing act. In recent years, most jurisdictions have included a requirement to include public or lay members on the governing body. In almost all cases, however, the regulating body is non-governmental, funded by nurse members and directed by a governing body with a majority membership of elected nurses.

Early Legislative Development: Nova Scotia was the first province in Canada to pass legislation providing for the registration of nurses. The provisions of *An Act to Incorporate the Graduate Nurses' Association of Nova Scotia*, passed in 1910, included:

- the incorporation of the Graduate Nurses' Association;
- the establishment of a board of examiners and an entry examination; and
- the power to discipline registrants.

In 1913, Manitoba became the second province to pass regulatory legislation for nurses. *An Act Respecting The Manitoba Association of Graduate Nurses* established a comprehensive registration system including an examination, educational requirements for registration, and title protection. Similar legislation adopting a permissive model of registration was passed by New Brunswick and Alberta in 1916, Saskatchewan in 1917, British Columbia in 1918, Quebec in 1920, Ontario and Prince Edward Island in 1922, and Newfoundland in 1953. In 1946, with the passing of the *Quebec Nurses' Act*, Quebec became the first province in Canada to have mandatory registration for nurses. By 1986, seven jurisdictions had mandatory registration requiring any person practicing nursing to be registered/licensed.

Role of Provincial Nurses Associations: Canada's professional nurses' associations played a key role in the movement toward formal organization begun in the late 1890's. It was these national and provincial associations that pushed for, and eventually obtained, legislation to regulate the standards of education and registration for nursing. By 1914, all provinces except Prince Edward Island had a provincial nurses' association, and by 1922 all nine provinces (Newfoundland had not yet joined Canada) had some form of nursing regulation to protect the public.

The responsibility for nursing regulation was originally granted to the professional nursing associations in all provinces. With the exception of Ontario, the professional and regulatory role remains combined in one association. (The professional nursing role in Canada does not include collective bargaining functions; see discussion in section on workforce issues.) In 1961, Ontario passed legislation to separate the roles of the professional association and the regulatory body. Philosophical debate over whether the regulatory and professional responsibilities should be separated has periodically surfaced in the other jurisdictions, but has not been followed up by their respective governments.

Summary of Form of Government:

- ***Canada is a federal state. Political power is distributed between the central (federal) government and the provincial/territorial governments. Provincial/territorial governments have the authority to regulate health professions.***
- ***Nursing regulation in Canada has its historical roots in a model of voluntary registration, which granted provincial/territorial nursing associations the right to self-regulation, established requirements for registration and provided title protection to Registered Nurses.***
- ***Two basic premises underlie nursing regulation in Canada. First, the purpose of nursing regulation is protection of the public. Second, subject to this condition, the provincial and territorial governments delegate nursing bodies the right of self-regulation.***
- ***Except in Ontario, the professional and regulatory role is combined in the provincial/territorial nursing associations.***

Geography

Canada is comprised of all of the northern part of North America (except Alaska) and is the second largest country in the world. It is bounded on the east by the Atlantic Ocean, on the west by the Pacific Ocean, on the north by the Arctic Circle, and on the south by the United States.

Historically, Canada forged extensive east-west transportation and communication links, beginning with the building of the Canadian Pacific Railroad in the 1870's. Despite these links, physical geography and discontinuous settlement have led to a strong sense of regional identity.

Summary of Geography:

- ***Canada is the second largest country in the world.***
- ***It is characterized by a strong regional sense of identity.***

Demographics

General Population: Despite being the second largest country in the world, Canada is sparsely populated. Before the arrival of European settlers, the native peoples of Canada were concentrated in the St. Lawrence Valley and on the Pacific West Coast. Subsequent population distribution has mirrored this pattern, and today most of the population is concentrated along a narrow strip bordering the United States. As a result, Canada has a vast, largely uninhabited North and a population that is more than 75 percent urban.

As of 1995, Canada had a population of nearly 29.6 million people, two-thirds of whom reside in Ontario and Quebec.

Nursing Population: In 1994, the number of registered/licensed RN's in Canada was approximately 264,900.[3] Of these, 88.5 percent were employed in nursing; 3.2 percent were employed outside nursing; 4.4 percent were not employed; and the employment status of 3.9 percent was unknown[4]. The number of PN's in Canada in 1994 was approximately 82,250[5], a proportion of three RN's to every one PN. In terms of the proportion of the nurses per general population, in 1994, there was one RN per 125 people, and one PN per 359 people.

Reflecting the fact that two-thirds of Canada's population resides in Ontario and Quebec, nearly two-thirds of RN's and PN's in Canada are registered in Ontario and Quebec. Ninety-six percent of Canadian nurses are female.

Official Languages: Canada has two official languages, English and French, and linguistic duality is an integral part of Canadian society. It is also an increasingly regional phenomenon, with the English-speaking minority decreasing in the predominantly French-speaking province of Quebec and the French-speaking minority decreasing outside Quebec. French is the primary language of over 80 percent of the population in Quebec, about 31 percent in New Brunswick, 4 percent in Ontario; and up to 3 percent in the rest of the country.

Cultural Composition: Canada has an official policy of multiculturalism, which is often referred to as a cultural mosaic. Canada's multicultural population is a result of both historic and contemporary immigration patterns. Immigration policy in the first half of this century focused on nation-building through immigration, largely from Europe and the United States. The range of source countries has broadened dramatically since 1961, and currently, two-thirds of immigration to Canada comes from Asia, Latin America and Africa. In addition, Canada has a large and growing aboriginal population.

Immigration continues to be an important aspect of Canada's population growth and is currently about 1 percent of Canada's population a year. The majority of immigrants tend to settle in urban centres.

Summary of Demographics:

- ***Canada is a sparsely populated country of vast size, characterized by regional distinctions, English/French linguistic duality, and diverse cultural composition.***
- ***In 1995, it had a population of about 29.6 million.***
- ***In 1994, there were approximately 264,900 RN's and 82,300 PN's in Canada.***

Health Care System

Public Health System: Canada's health care system is based on the principle of universal access. This access is currently provided through publicly funded health care insurance programs, which provide universal coverage for hospital and medical costs. Between 9 and 10 percent of Canada's Gross Domestic Product is spent on health care, and on average, health care represents about one-third of the provincial and territorial budgets.

The health of the public in Canada falls within the jurisdiction of the provincial governments. The *Constitution Act* explicitly gives them the authority to make laws regarding the provision of health services, the operation of health insurance programs and the regulation of occupations and professions. Each province administers a health insurance plan to cover the costs of health care for its residents. The costs of the program are shared between the federal and provincial/territorial governments.

The federal government does not have authority to regulate directly the delivery of health care in the provinces, but it has exercised significant indirect control through its fiscal power and through the provisions of the *Canada Health Act*, which sets out the terms under which federal funding of health care is provided. The five basic principles of the *Canada Health Act* are:

- public administration (administered on a non-profit basis by a public authority responsible to the province/territory);
- comprehensiveness (all medically necessary hospital, physician and surgical-dental services must be insured);

- universality (all insured persons must receive insured health care services on uniform terms and conditions);
- portability (Canadians are insured for health services outside their province or territory of residence, both elsewhere in Canada and outside the country); and
- accessibility (insured health services must be provided on uniform terms and conditions and on a basis that does not impede or preclude access, directly or indirectly).

Jurisdictions allowing private health care for health services included under the federal funding umbrella are in breach of the Act.

The federal government has used the *Canada Health Act* to withhold transfer payments to those provinces whose health care insurance plans do not comply with these principles. The federal government's control, however, appears to be diminishing as it reduces federal transfer payments to the provinces. As a result, some provinces are considering extending the circumstances in which private health care can be offered.

The federal government is directly responsible for service delivery to a number of client groups, including members of Canada's aboriginal people (registered Indians and Inuit) and prospective immigrants. As part of its service to Canada's aboriginal people, the federal government operates health centres and nursing stations in isolated and semi-isolated Indian and Inuit communities across Canada. Since the development of the Indian Health Transfer Policy in 1986, the federal government has begun the process of transferring administrative control of health care services to the members of these native communities.

All Canadian jurisdictions are undergoing significant reforms to their health care systems. (See section on "Emerging Trends and Regulatory Issues in Canada").

Impact of Fiscal Constraints: Fiscal constraints are forcing the federal and provincial/territorial governments to either put a ceiling on or reduce health care funding. Restructuring and rationalizing existing services and systems, redistributing resources from acute care to community and longterm care, and changing mixes in health care providers are just some of the changes and pressures affecting Canada's health care system. Achieving consensus on the balance among fiscal efficiency, effective health care strategies and safe patient care is difficult, and there is growing public concern about the feasibility of maintaining Canada's public health system.

Summary of Health Care System:

- ***Health of the public falls in the jurisdiction of the provincial governments. The authority to make laws regarding the provision of health services, the operation of health insurance programs and the regulation of health professions lies with the provinces.***
- ***While the federal government cannot directly regulate the delivery of health care in the provinces, it has historically exercised significant indirect control through its fiscal power and the provisions of the Canada Health Act.***
- ***The ability of the federal government to maintain national standards over the health care system is diminishing in proportion to reductions in federal health funding transfers to the provinces.***
- ***Canada's health care system is a publicly funded, universal system. Fiscal constraint, however, is putting the system under considerable stress.***

Workforce Issues

About 7 percent of the Canadian workforce is employed by the health care system, and about three-quarters of health care expenditures are allocated to fees and salaries. The largest single group of health care providers are nurses.

In 1920, the first nursing union to address workplace issues was established in Montreal, Quebec. In 1946, the British Columbia RN Nursing Association assumed a collective bargaining role. Over the next two decades, more nursing associations across Canada also took on collective bargaining roles. By the 1970's, however, a conflict of interest was alleged, and separate provincial and territorial nursing unions began to form and assume the collective bargaining role from the professional bodies. None of the nursing associations now has any collective bargaining responsibilities.

Many provinces and territories have a strong autonomous union for RN's, and provincial/territorial-level collective bargaining agreements that establish common conditions in unionized facilities across the province are common. In other provinces and territories, there is no separate RN union and the RN's are represented by a union of government employees generally. In 1981, a national federation of provincial/territorial RN unions was established (the National Federation of Nurses' Unions). Six provincial unions currently belong.

Autonomous unions for PN's have also developed, although PN union membership tends to be more widely dispersed among unions representing a range of service workers.

A high proportion of those nurses eligible to join a union are union members. In the case of RN's, they are most often members of a nursing union. Membership ranges from 80 to 95 percent in Newfoundland and British Columbia to about 55 percent in Ontario. In general, these figures reflect a strong union presence in hospitals, where a large proportion of nurses eligible to join a union are employed. Maintaining this level of membership, in light of nursing job losses due to the closing of hospital beds and the shift to community care, is a challenge facing most nursing unions.

Common nursing workforce issues identified in both unionized and non-unionized settings include the limits which facility managers and/or physicians place on the ability of nurses to practice to the full extent of their scope of practice and competency level; the growing disappearance of nursing executives/managers who understand the workplace needs of nurses; and concerns about the impact of greater patient loads and acuity levels on the ability of nurses to provide safe and effective care.

Summary of Workforce Issues:

- ***There are strong provincial/territorial nursing unions that function independently from the nursing associations.***
- ***A substantial proportion of Canadian nurses eligible to belong to a union are union members.***
- ***Health care restructuring and changes in health care provider mixes are creating workplace concerns for nurses.***

Historical and Societal Issues and Trends

Canada's distinctive approach to the regulation of nursing bears the imprint of Canada's political and social history. Issues of cultural autonomy and community identification have dominated Canadian political life. For example, federal debate has focused on the relative authority of the federal and provincial and territorial governments to make laws in specific areas. Debate over language rights has focused on the autonomy of French-speaking Canadians and the preservation of their unique culture. The political activities of Canada's aboriginal peoples have focused on land claims, powers of self-government, and native rights. Political debate over health also has had a similar focus on competing national and regional interests.

This framework has shaped the overall structure of regulatory authority for nursing in Canada. A decentralized structure has resulted in structural variances in regulation across the provinces. Despite these variances, there are a number of important similarities. Nursing in all provinces is a self-regulated profession with a common responsibility: the regulation of nursing in the public interest.

Professional nursing associations, including the Canadian Nurses Association (the national association of the professional nursing associations) have pressed for legislation that would protect the public by establishing standards for education and registration. Eventually, the provincial and territorial professional organizations were delegated the responsibility of regulating their profession in the public interest.

Concern over quality and access to health care did not begin with the establishment of Canada's universal health care system. The nursing profession in Canada has been working for over a century to provide Canadians with high quality health care through the establishment of standards of nursing education and practice, and the provision of equitable, quality health care has been the driving force behind the development of nursing regulation in all provinces. These goals have been achieved despite numerous barriers and constraints to the development of the nursing profession in Canada.

In many Canadian jurisdictions, nursing has its roots in the Catholic religious orders which accompanied the first settlers to the country, and the profession has had to overcome the perception of nursing as a charitable vocation often associated with these roots. Combating this perception was made more difficult by the historical difficulties faced by nursing as a female-dominated profession, both in terms of nursing's place in the health care hierarchy and the balancing of work and family responsibilities.

In the 1920's, medical and health care shifted from home and community-based settings to the complex organizational structures of hospitals and other facilities. These organizations established their own rules and controls around the "permissible" role of nurses, which became deeply entrenched. The exclusive licensure model used to regulate medicine also constrained the role of nurses, because it gave physicians authority to prohibit nurses from performing acts within medicine's scope of practice without medicine's consent.

Nursing autonomy also has been affected by Canada's health care funding system, which prevents nurses from

accessing public health care funds and reinforces the continued constraints placed on the nursing practice role by employer health facilities and professions.

Despite these barriers, the nursing role has continued to develop, for many of the same reasons which have influenced nursing in the United States. These include the growth in the opportunities provided by both World Wars for nurses to assume responsibilities that previously had not been seen as part of the nursing role. Two quite different developments in the 1970's further stimulated nursing in Canada.

One development was a commission of inquiry into the prosecution and subsequent dismissal of a criminal case against an RN charged with administering fatal overdoses of digoxin to a number of infants. This case galvanized Canadian nurses, who perceived that the nurses involved were used as scapegoats by the medical and judicial establishments. The case can be seen as a benchmark in nursing's ongoing advocacy for recognition and treatment as an independent and equal health profession.

The other development was Canada's leadership in the development of the World Health Organization's statements supporting a shift from the medical curative model to a health determinants approach to health promotion. The congruence between the determinants of health model and the holistic care philosophy of nursing strengthened government and public acceptance of the nurse's role in a new paradigm of health care. Canada's continued activity in research supporting the relationship between socio-economic factors and health has continued to keep the holistic approach to health care in the public's awareness. However, government commitment to the health determinants model in the context of Canada's current economic crises and resulting cutbacks in federal and provincial/territorial social programs is uncertain. The impact of this possible shift on the development of the nursing role is not known.

Summary of Historical and Societal Trends:

- ***The professional nursing associations have played a key role in achieving and maintaining the long history of self-regulation of nursing in Canada.***
- ***The historical and societal issues that have shaped the development of nursing in Canada have much in common with the issues that have shaped nursing in North America and Europe: the historical role of women in the workplace, societal and cultural perceptions about the role of nurses and nursing in particular, and medicine's authority over nursing's scope of practice.***

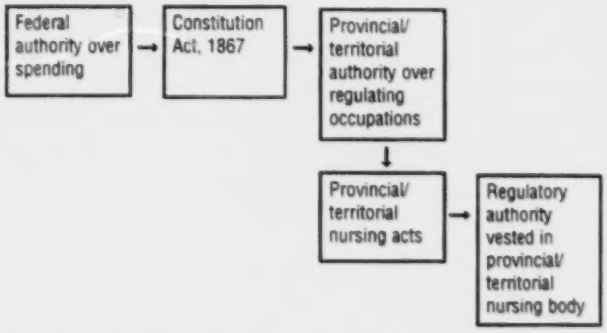
Current Status of Licensure/Registration

Locus of Authority for the Regulation of Nurses

Foundational Laws and Processes

The authority to regulate nursing flows from provincial jurisdiction over occupations and professions. Through provincial or territorial nursing acts, regulatory authority is delegated by the provincial/territorial governments to the nursing profession.

Structure of Authority


Federal authority over spending
Constitution Act, 1867
Provincial/ territorial authority over regulating occupations
Provincial/ territorial nursing acts
Regulatory authority vested in provincial/ territorial nursing body

Sometimes the nursing acts are part of omnibus regulatory legislation, which may either be specific to health disciplines or govern general occupations and professions. Omnibus legislation is used here to refer to a common statute that governs all the professions listed and is usually supplemented by a profession-specific statute.

Common Responsibilities: While the legislation and its provisions are unique to each province and territory, they have many similarities. Legislative authority usually includes responsibility for:

- developing or establishing:
  - the qualifications required to be registered, i.e., entry to practice criteria;
  - the types or levels of registration, e.g., practicing/ non-practicing, temporary;
  - the fees for maintaining current registration/ licensure; and
  - the standards of practice necessary to assure the quality of the profession:
- monitoring the continuing competence of members:
- investigating and adjudicating complaints and administering professional discipline.

The regulatory body in all jurisdictions, except Alberta, Ontario and Quebec, also approves and/or accredits nursing education programs.

Other provisions found in most nursing acts include the scope of practice of the profession, protecting or limiting to members the use of nursing-related titles, and balancing the public's right to information about the registration status of members while protecting member privacy. The acts also set out rules and procedures relating to the administrative or quasi-judicial responsibilities of the regulatory body, e.g., discipline hearings.

In addition to nursing specific legislation, most nursing regulatory bodies are also subject to separate legislation governing the conduct of all administrative tribunals, e.g., the Ontario *Statutory Powers Procedure Act*, and to general corporate law relevant to the conduct and operation of the regulatory body.

Separate Regulation of RN's and PN's: Most provinces have separate regulation of RN's and PN's, although in Ontario, both are regulated under the same legislation. The method of regulating PN's varies from province to province including, for example, regulation by a government agency, self-governing legislation, or special legislation establishing a Council of Practical Nurses.

Nature and Structure of Regulatory Body

RN regulatory bodies in Canada are not government boards or agencies. They have an independent legal structure, usually of a non-share or statutory corporation, and are funded through member fees; no government funding is received. Most, but not all, PN regulatory bodies also have an independent, non-government structure.

The majority of members of the governing board or council of the regulatory body are elected members of the nursing profession. More recently, most nursing acts also require public or lay members, usually appointed by the government, on the governing board or council.

Generally, the acts also set out specific committee structures and membership for dealing with regulatory functions, such as registration, complaints and discipline.

How Members of Regulatory Body are Appointed: In most instances, the nursing members of the governing boards or councils of the regulatory bodies in Canada are elected or selected by the members of the profession, in accordance with the jurisdiction's nursing act or the organization's bylaws or articles. In the case of the RN regulatory bodies, the nursing members are generally elected by the RN's in the province, usually on a regional basis.

The public or lay members of the board or council may be appointed directly by the government or by the professional association, depending on the requirements of the legislation. In some jurisdictions, stipends and expenses of public members appointed by government are paid by the government, and in others by the association. All other member costs and expenses are paid by the regulatory body in accordance with its regulations, by-laws or articles.

Public Accountability for Regulation: Public accountability is a key component of self-regulation, and public members play an important role in ensuring this accountability. The trend clearly points to increased public involvement in professional regulation in the future. All provinces are increasingly aware of the need to consult with and solicit the involvement of the public whom they are mandated to protect.

Another recent mechanism for strengthening public accountability for regulation is the establishment, by government, of an advisory council or agency responsible for monitoring the activities of the professional regulatory bodies and/or advising government about regulatory issues of public interest. These councils have already been established or are being considered by a number of provinces.

Other accountability mechanisms that may be imposed include requiring an annual report to be submitted to government, council or board meetings that are open to the public, or the public release of the findings of disciplinary hearings.

Other Regulatory Controls: In addition to professional regulation, the practice of nurses in Canada is subject to multiple regulatory controls in the workplace, including legislation governing hospitals and longterm care facilities, occupational health and safety legislation, labour legislation, provincial or territorial human rights legislation, and the federal *Charter of Rights and Freedoms.*

Summary of Foundational Laws and Processes:

- ***RN's and most PN's are self-regulated. Regulatory authority is delegated by the provinces to the nursing profession.***
- ***Most provinces have separated the statutory authority for regulation of RN's and PN's. Ontario has joint regulation of these two categories.***
- ***Public accountability is a key component of self-regulation. Most provinces now have government appointed public members on their board or council.***
- ***Nurses in Canada are subject to multiple regulatory controls: professional regulation, workplace legislation, labour legislation, and human rights legislation.***

Defined Levels

Entry Levels: All provinces regulate registered nurses (RN's) and practical nurses (PN's) and set out the scope of practice of the profession. The four western provinces (Alberta, British Columbia, Manitoba and Saskatchewan)also regulate registered psychiatric nurses under separate legislation

RN's in Canada are required to successfully complete a diploma or a baccalaureate (e.g., BScN) nursing education program. Diploma RN's receive their nursing education in five to six academic semesters in a post-secondary education program at a community college or, in a few cases, a hospital-based school of nursing. Baccalaureate RN's receive their nursing education in an eight academic semester university nursing program. A unique Master's program is offered by one Quebec university. Master's degree students can complete a six academic semester, basic RN program concurrently with the Master's degree program. These students already have a baccalaureate degree in the arts or in the sciences, though not in nursing, before they enter the program.

There is strong nursing professional and educational support for restricting entry to practice as an RN to graduates of nursing baccalaureate programs. Six provinces (Newfoundland, Prince Edward Island, New Brunswick, Nova Scotia, Manitoba and Saskatchewan) are amending their entry to practice criteria to require a baccalaureate degree in nursing for entry to practice as an RN. Nurses with diploma preparation who already are registered will continue to be registered.

The entry to practice requirements and the duration of the psychiatric nurse program are similar to those of the RN programs.

PN education programs are two to three academic semesters in duration, depending on the province or territory. A significant proportion of these programs are offered as post-secondary programs in community colleges; others are offered in hospital-based schools or as cooperative programs in secondary schools. Generally, the PN scope of practice requires that the PN perform under the direct or indirect supervision of an RN. An exception is Ontario, where the regulatory standards of practice allow PN's to perform autonomously in prescribed circumstances.[6]

Advanced Levels: The definition of an "advanced level" RN and whether she or he should have separate registration and advanced level title protection are matters of extensive discussion by the Canadian nursing profession. Currently, there is no consensus on the definition, need for, or manner of additional forms of regulation for this group, and no province or territory has established separate regulatory levels for advanced-level RN's.

The Ontario government is studying proposed legislative amendments that would give RN's with advanced knowledge and decision-making skills as primary care nurse practitioners the authority to autonomously initiate extended health services such as diagnosis and prescribing (which nurses are not currently authorized to do). Alberta has recently amended its *Public Health Act* to allow RNs to provide extended health services (diagnosis, treatment and referrals). Whether or not to have some form of specific regulation for these nurses is under discussion.[7]

Unregulated Levels: Unregulated health care providers is a term usually used to refer to providers such as health care aides, personal support workers, homemakers, respite care workers, unit assistants and patient care assistants who are not subject to direct professional regulation. However, they are often subject to indirect regulation through legislation governing employers, such as public hospitals and nursing homes. These providers have always been part of the health care system. Their numbers are increasing and the settings in which they provide care are becoming more diverse as fiscal constraints and restructuring of the health care system lead employers to hire less costly providers. Their preparation can range from on-the-job training of a few weeks, to several months in a vocational or community college program.

Although nurses across the country are expressing increasing concern about the need for stronger mechanisms to ensure that these providers are not placed in situations beyond their competence, accountability for these providers lies predominantly with employers. As of 1995, provincial and territorial governments have not established formal systems of external regulation or registration, and nursing regulatory bodies have no authority over these individuals.

Summary of Defined Levels:

- ***Three entry levels of nurses are regulated: RN's, PN's, and registered psychiatric nurses. The latter is a small group found only in British Columbia, Alberta, Saskatchewan and Manitoba.***
- ***RN's must have completed either a five to six academic semester diploma nursing program or an eight academic semester university nursing program.***
- ***PN's must have completed a two to three academic semester practical nurse program. The scope of practice of practical nurses in most provinces require PN's to perform under the direct or indirect supervision of an RN. An exception is Ontario, which considers PN's to be independent practitioners.***
- ***Currently, there is no special regulation of "advanced" level nurses in Canada, and the nursing regulatory bodies do not have direct authority over unregulated health care providers.***

Initial Requirements for Entry into Nursing Practice

Examination

Until 1985, every province and territory in Canada required a passing score on an approved registration examination as a condition of entry to practice as either an RN or a PN. In 1970, the nursing regulatory bodies adopted common national RN and PN examinations prepared by the Canadian Nurses Association Testing Services (CNATS). Currently, all provincial and territorial registering bodies for RN's and PN's require this examination, known as the CNATS examination. The only exception is Quebec, which uses the CNATS RN exam but not the PN exam. Quebec has used the English RN exam since 1970 and the French RN exam since 1980.

Prior to adoption of the CNATS examination, all provinces except Ontario, New Brunswick and Quebec (for the French RN examination) purchased the U.S. State Board Test Pool Examination (SBTPE) for use as their provincial or territorial examination for RN's. Ontario had developed its own examination, which New Brunswick purchased. The SBTPE was similar to the 1970 Canadian national examination and was considered equivalent until all provinces/territories adopted a revised comprehensive CNATS exam in 1982. For this reason, some provinces accept the SBTPE for RN's if it was written before a specified time.

Until July 1995, the CNATS examination was norm-referenced, that is, an individual candidate's score was interpreted relative to the scores of the other candidates. However, as of August 1995, the RN CNATS examination is criterion-referenced and examinees receive a pass/fail score. The criterion-referenced examination will be in place for the PN examination as of June 1996.

***Nature and Structure of Examination*[1].** The examination, which is available in English or French, consists of 240 to 260 multiple-choice questions, each of which is designed to measure a specific competency required of nurses beginning to practice. It is prepared in accordance with the *Blueprint for the Criterion-Referenced Nurse Registration/Licensure Examination*, September 1993, prepared by the Testing Division of the Canadian Nurses Association. The *Blueprint* sets out the technical specifications for the preparation of the national examination. It has two major components: the content domain to be measured, and explicit guidelines on how to undertake the measurement.

Content: Seven categories of nursing competencies are tested: the collection of data based on a conceptual framework of nursing; the analysis and interpretation of client data; planning the nursing care; safely and effectively implementing the plan of care and nursing interventions; evaluating the effectiveness of the plan of care and modifying it as necessary; collaborating and coordinating with members of the nursing and health care team; and professional practice, i.e., practicing within professional, legal, and ethical standards.

These competencies are subdivided and weighted according to whether they are very important or important, and according to the frequency and difficulty of execution for the beginning practitioner.

Guidelines: In addition to the specifications relating to the competencies, the *Blueprint* sets out guidelines on two types of variables: structural and contextual.

The structural variables address the characteristics that determine the general appearance and design of the exam, e.g., length, format. The exam is divided into two books administered in one day. Three and one-half hours are provided for completion of each book. Forty to fifty percent of the questions are presented in a case-based format, i.e., a group of approximately five questions that are associated with a brief introductory text. All the remaining questions are presented in an independent format. A few are experimental questions, that are being

tried out to determine suitability for use on future exams and are not counted in the candidate's score.

Each item on the exam is classified into either a cognitive or affective domain. The cognitive domain, which consists of knowledge and comprehension, application, and critical thinking, was previously tested in the norm-referenced exam. Testing of affective domain competencies, such as attitude and judgment, is being conducted for the first time in the criterion-referenced exam.

The contextual variables include client age, gender, culture and health situation, and the health care environment.

Conditions for Taking

Diploma and baccalaureate prepared applicants for registration as an RN write the same examination. Candidates must complete an application and pay the prescribed exam fee to the nursing regulating body for which entry is being requested. Eligibility to write the exam is determined by the regulatory body and is usually dependent on acceptable demonstration of successful completion of an approved nursing education program or equivalent, and on meeting other specified criteria.

Orientation of Examination: The basis of the CNATS examination is testing the competencies which a beginning nurse is required to possess in order to practice safely and effectively. The beginning nurse is defined as a nurse who, on entry into practice and regardless of educational preparation, is working as a generalist in an entry-level position.

The competencies are developed from a nursing focus, which includes the inherent belief that nurses take a holistic view of human beings, who have the capacity to set goals and make decisions, and who have the right and responsibility to make informed choices congruent with their own beliefs and values.

Validation of Content: Rigorous psychometric testing standards are followed in the development and administration of the exam. A comprehensive review of the 1993 *Blueprint* is planned for 1998, and annual evaluations will be conducted to affirm that the competencies and guidelines continue to reflect expectations of a nurse beginning to practice.

Construction of Examination: The exam questions, or items, are developed and evaluated by representatives of all the Canadian nursing regulatory bodies and by nursing experts from across Canada including nurse educators, clinicians, and administrators. Expert panels of nurses review each question to ensure the question reflects current practice standards in each province/territory. Some provinces also hold jurisdictional review sessions to ensure that exam items are consistent with the province's standards of practice.

Scoring Basis for Determining Passing: The exam is computer scored and only answers recorded on the answer sheets are scanned and scored. Prior to introduction of the criterion-referenced exam, a score of 350 was required to pass the exam by all provinces for both the RN and PN norm-based exam.

Results on the criterion-referenced exam are reported as a pass or fail result, which is determined by comparing the score to an established standard or pass mark. This standard is established prior to the administration of the exam. It is set in reference to the content and difficulty of the test questions. Panels of subject matter experts from across Canada rate the exam questions on the basis of the expected performance of a minimally competent RN or PN beginning to practice. In addition to the expert ratings, other relevant data are considered to ensure that the standard is valid and fair. This can include information on the preparation of new graduates, data on the performance of candidates on previous exams, and relevant research findings.

Process for Eliminating Bias: Each item on an examination has been reviewed by a Test Fairness Review Group, which advises the CNA Testing Services on whether there are test items that may disadvantage a candidate on the basis of race, national or ethnic origin, religion, sex, age, or disability. The members of the Fairness Review Group are not necessarily RN's or PN's. The group consists of at least four members, appointed by the CNA Testing Services from nominees representative of the race, origin, colour, religion, sex, age or disability of the candidate pool and client population.

Process for Assuring Fairness and Security: Fairness and security are assured at two levels:

- **Exam Questions:** Test equating is done so that candidates will achieve the same examination result (pass or fail), regardless of the form or language of the examination written. A predetermined set of questions, known as anchor questions, appear on all exam versions. Although there are different versions of the exam containing different sets of questions, the use of anchor questions and of a common measurement scale ensures that all candidates are treated fairly and are evaluated against the same standard.

Confidentiality is expected of all item writers and reviewers, and exam questions are maintained under secure conditions.

- **Exam Administration:** The exams are administered by the provincial or territorial regulating bodies across the province, in a monitored and standardized fashion[9]. Admission to the exam room requires production of an identification card issued by CNA Testing Division and forwarded by the regulatory body. Other aids are not permitted. However, candidates with a disability that could adversely affect their performance on the exam can request testing accommodation.

Retake Process

A profile of the strengths and weaknesses reflected in the exam of a failing candidate is compiled by CNATS and is sent to the candidate by the registering body. Hand tabulation of the answer sheets will be provided by the CNA Testing Division, and there is a process that allows the candidate to arrange to hand tabulate her or his own test. Application for hand tabulation must be made to the registering/licensing body within 45 days from when the examination results are mailed. There is a fee for this service.

The RN exam is offered four times a year and the PN exam three times a year. The timing for retake of exams is constrained by the exam schedule. Computerized adaptive testing, which will allow individually-tailored exams that can be offered at any time, is not yet available, although this has been identified as an early goal.

Most provinces and territories have established rules and criteria setting out how often an examination may be retaken within a specified period, and whether a nursing upgrading program must be taken before the candidate is allowed to retake the examination.

Other Entry to Practice Criteria

Registered Nurses: In addition to successful completion of the national registration examination described above, all provinces have a number of other common requirements for registration at the RN level. These include:

- payment of the prescribed registration/licensure fee;
- proof of legal name;
- graduation from an approved nursing program or equivalent (Programs include both a theoretical and practice component, and the number of hours of theory and clinical practice required in provinces, varies);
- evidence of recent practice and satisfactory employment references, or evidence of recent study;
- character requirements; and
- language requirements, i.e., proficiency in English or French.

Individual provinces have imposed additional criteria. Appendix A sets out the specific details of the requirements for initial registration as an RN in the provinces/territories.

Practical Nurses: As with the registration requirements for RN's, there are common requirements for registration as a PN across all provinces and territories, with individual provinces imposing additional requirements.

National Nursing Competency Project: A collaborative project among Canadian nursing bodies is currently underway to develop entry-level competencies for registered nurses, licensed practical nurses and registered psychiatric nurses. The project officially began in February 1995 and will be completed by mid-1996. Its purpose is to develop competency statements that will focus on the combined knowledge, skills, attitudes and judgement expected of the nurses at the time of entry into the profession in 1996 and in the future, in 2001.

Three national nursing associations and 26 Canadian nursing regulatory bodies are currently collaborating on the National Nursing Competency Project. All 12 provinces/territorial jurisdictions, the Canadian Nurses Association, the Canadian Association of Practical Nurses and Nursing Assistants, and the Psychiatric Nurses Association of Canada are involved in this project.

Summary of Entry to Practice Requirements:

- ***RN's and PN's in Canada are required to successfully complete the CNATS examination, a standardized, national examination to test competency for entry into practice. The only exception is PN's applying for entry in Quebec.***
- ***The same examination is taken by RN's with diploma and baccalaureate preparation.***
- ***The CNATS exam is prepared by the Canadian Nurses Association in collaboration with the provincial and territorial nursing regulatory bodies, and in accordance with rigorous psychometric testing principles and principles of fairness. It is administered in the individual provinces by the provincial or territorial nursing regulatory body.***
- ***There is a consistent base of other common entry requirements, which include successful completion of a nursing education program approved or endorsed by the nursing regulatory body, and facility in English or French. Submission of a formal application and application fee is also required.***

Ongoing Licensure

Renewal/continuance

Renewal or continuance of registration of RN's and PN's requires payment of an annual fee and generally requires meeting recent practice or recent study requirements. The requirements for evidence of recent practice for renewal are the same as those for initial registration.

Re-entry

Following Lapse or Suspension of Registration: Re-entry or reinstatement of individuals whose registration has lapsed or been suspended because of non-payment of fees is usually treated as a relatively simple administrative matter. Applicants are generally permitted to bring their registration into good standing upon payment of the outstanding fees and/or a penalty fee, and upon demonstration of recent competency to practice, where this is required. Individuals who are not able to meet the recent practice requirement, i.e., have been out of practice for a specified period of time, are usually required to complete an upgrading, refresher or nurse re-entry program before being eligible for re-entry.

Following Revocation Pursuant to Discipline Proceeding: Reinstatement to the profession following revocation is dealt with on a case-by-case basis. Any additional conditions that were imposed as a result of the disciplinary proceeding must have been met, and the reinstatement application may be referred to the Discipline Committee for consideration. Some provinces have conditions that impose time frames before applications for re-entry can be made. All applications require payment of a fee.

Continuing Competence

Aside from the requirements of most jurisdictions that annual renewal requires evidence of recent practice (expressed as a specific number of hours in all jurisdictions except Ontario and Quebec) as a measure of competence, the provincial and territorial regulatory organizations have historically considered continuing competence in a passive rather than an active manner. Most provinces have relied on employer accountability for ensuring the competence of nurse employees, though some jurisdictions require employers to report to the regulatory body RN's and PN's who have been discharged for incompetency, incapacity or misconduct. Failing such reports, and in the absence of any complaints about a member, general professional accountability to maintain competence has been relied upon to ensure ongoing competence.

More recently, quality assurance and continuous quality improvement have been matters of considerable discussion, and in at least one jurisdiction, there is now a legislated requirement for a formal continuing competence program. It is expected that the competencies identified in the National Competency Project will provide a basis on which additional continued competency requirements can be developed.

Summary of Ongoing Licensure:

- ***All provinces impose an annual fee for the renewal or continuance of registration as an RN or PN, and most require evidence of recent practice.***
- ***Generally (and assuming that evidence of recent practice is not in question), re-entry after suspension or lapse due to non-payment of renewal fees is dealt with as a procedural matter that can be addressed by payment of the required fees, often including a penalty fee.***
- ***Re-entry after revocation following a disciplinary matter is more difficult and generally requires satisfactory demonstration to the regulatory body of why re-entry should be permitted.***
- ***Consideration of requirements other than evidence of recent practice to demonstrate continuing competence is still in preliminary stages.***

Mobility

Within Country

Since registration is a matter of provincial or territorial jurisdiction, an RN or PN registered in one jurisdiction in Canada must apply to be registered in another jurisdiction in Canada, if she or he wishes to be registered in the other jurisdiction. Subject to the authorized discretion of the regulatory body, the applicant must meet the entry requirements of the new jurisdiction, even if some of these differ from the requirements of the originating jurisdiction.

For example, some jurisdictions authorize PN's to administer medication. These provinces require PN's from provinces without medication administration to take the necessary medication administration education component and to successfully write that part of the CNATS exam relevant to medication administration before giving registration.

Nevertheless, all of the nursing regulatory bodies work in close and ongoing collaboration to develop consistent criteria and find ways of facilitating the mobility of applicants who are already registered in another Canadian province or territory. There is an agreement or mutual endorsement among the nursing registering authorities to recognize the approved nursing education programs in each province. Under this endorsement, a nurse who receives her or his nursing education in one province or territory will generally be considered to have met the education entry to practice requirement in another. The common national CNATS examination also facilitates mobility.

From Other Countries

RN's and PN's from outside Canada must meet all of the entry requirements of the selected province or territory. The first step is determining if the nursing education program completed in the originating jurisdiction is equivalent to the provincial or territorial approved programs. Equivalency is generally determined by the regulatory body receiving the application. Equivalency requires evidence of theory and practice in each of the subject areas contained in the provincial or territorial program. The total number of hours of theory and clinical practice must be equivalent to the minimum required in the provincial or territorial program. There is usually also a requirement for evidence of recent practice.

If the applicant's basic nurse or practical nurse program is equivalent and the recent practice requirement has been met, the applicant is eligible to write the national examination. If the basic program is not equivalent, some regulatory bodies may consider whether compensatory factors, such as employment experience, may be sufficient to make up the deficiency. If these criteria are not met, the applicant will be required to take a course or courses in the deficient areas or to complete an approved re-entry program. The other requirement for applicants from other countries is fluency in English or French.

The nursing regulatory authorities across Canada meet annually to identify common registration principles and to strive for harmonious requirements to assist nurse mobility within Canada. They also work to identify common criteria to assess these requirements. It is hoped that the development of consistent competencies across jurisdictions through the National Competency Project will facilitate replacing the measurement of learning processes with the measurement of learning outcomes, and an evaluation of whether the program content is consistent with the Canadian jurisdiction's standards of nursing practice.

Summary of Mobility:

- ***Nurses in Canada crossing provincial or territorial boundaries are required to meet the entry requirements of the new jurisdiction. This is facilitated by the fact that the nurse already will have completed the national examination, and subject to some restricted variations, by agreement among the regulatory bodies to give equivalency to approved Canadian nursing programs.***
- ***Nurses from outside Canada must meet all the requirements of the regulatory body.***
- ***Equivalency of out-of-country nursing programs is assessed and determined by the regulatory body.***
- ***The Canadian nursing regulatory bodies work collaboratively to facilitate nursing mobility.***

Regulatory Standards

Definition and Focus on Regulation

Regulatory standards are authoritative statements that describe the responsibilities for which its practitioners are accountable. In addition to providing direction for nursing practice, standards reflect the values and priorities of the profession. They are articulated in laws, rules and policies that govern the conduct of members of the profession.

Sources

Government

In keeping with the premise of self-regulation, government in Canada plays a limited role in directly establishing professional regulatory standards, although there are a number of indirect sources of government regulatory standards. These include the Charter of Rights and Freedoms, which is part of *Canada's Constitution Act*, and the *Canadian Criminal Code*, which is federal legislation. Provinces and territories also have human rights legislation that establishes principles of nondiscrimination based on factors such as race, colour, creed, gender and disability. Additionally, members are subject to the common law governing the conduct of professionals and their relationships with clients, and to various provincial or territorial acts dealing with issues such as consent to treatment or admission to care facilities.

In terms of direct government regulatory standards, some nursing acts impose limited regulatory standards such as requiring employers to report to the regulatory body nurses who are discharged due to incompetence or incapacity, and mandatory reporting by all regulated health professionals of sexual abuse of a patient or client by a regulated health professional. When the registering body wishes to have professional misconduct standards incorporated into legislation or into regulations under legislation, the consent of the provincial or territorial government is required.

Self-Regulation

The primary responsibility for establishing regulatory standards for RN's and PN's in Canada, however, lies with the registering or licensing bodies, which are explicitly required to establish nursing standards of practice by the registration acts. This concept of standards of practice being established by the profession itself is viewed as one of the keys to the concept of self-regulation as it is understood in Canada. An exception is the Northwest Territories, where the Department of Education is responsible for setting standards of practice for PN's.

In addition to setting the standards of clinical practice, the regulatory bodies establish ethical and professional conduct standards, define professional misconduct, and articulate other policy or position statements. In some cases, these standards, particularly misconduct provisions, are incorporated into the registration act either directly or by regulations under the act. In other cases, they are issued as directives, policy statements, guidelines, etc. Whether or not they are incorporated into the legislation, they are binding on members and can be legally enforced by the regulatory body.

Regulatory standards are not all established directly by the regulatory body or by government. For example, a Code of Ethics has been developed by the Canadian Nurses Association. Many jurisdictions, as members of the national association, adopted the Code as their standards. In Ontario, where the professional and regulatory organizations are separate, the professional bodies also develop standards and position statements on nursing roles and responsibilities. Professional standards, which are widely understood and accepted within the profession, are also regulatory standards even though they may have been developed by non-regulatory professional bodies. In the event there is a conflict, the standards established by the regulatory body generally take precedence.

Self-regulation, as it is understood in Canada, refers to a collective privilege given to a profession as a whole (through a regulatory body composed and governed predominately by its own members) to regulate itself. Another aspect of self-regulation, however, is the personal accountability of individual members to honour and comply with the standards of the profession, and to be personally responsible for not performing beyond her or his level of competence. This personal accountability is one of the fundamental precepts of the nursing standards in all jurisdictions.

Types

The literature on regulatory and nursing standards articulates a number of ways of categorizing or grouping regulatory standards. For the purposes of this chapter, the types of regulatory standards are categorized as general professional standards, nursing standards, ethical standards and direct nursing care standards.

General Professional Standards

General professional standards are comprised of those standards relating to a member's professional conduct. There is variation in some of the terminology used, but examples of general professional standards found across Canada include complying with legal and professional obligations; maintaining the standards of practice of the profession; practicing within the profession's scope of practice; not working while impaired; not abusing a patient, stealing or breaching confidentiality; and not performing beyond one's competence level. A general catch-all standard, that members conduct themselves in an honourable, proper or professional manner, covers behaviour not explicitly set out in the professional standards.

Nursing Standards

For purposes of this chapter, nursing standards are those relating to nursing process, the organizing and managing of care, and professional and legal accountability for nursing services. There are four broad types of nursing standards: structure standards, which outline the administrative process needed for activities to take place; process standards, which are guidelines identifying how nursing activities are carried out; outcome standards, which identify the results expected from adherence to structure and process standards; and evaluation standards, which are quality control mechanisms to identify the appropriateness and effectiveness of the outcomes of the structures and processes.

For the most part, nursing standards in each province have components of both structure and process standards, though there is a beginning movement toward continuous improvement through the use of outcome standards. There are as many approaches to articulating nursing standards as there are nursing bodies.

Ethical Standards

Ethical standards deal with the relationship between the nurse and the patient or client and with the values and behaviours that are expected to govern the nurse in the conduct of the relationship, e.g., client well-being, client autonomy and choice, sanctity of life, truthfulness, fairness, trust, advocacy for the client, and beneficence. As noted above, the Canadian Nurses Association has developed a Code of Ethics (which it is currently revising) that has been adopted by many jurisdictions.

Direct Nursing Care Standards

These standards are defined for the purposes of this chapter as protocols or directives relating to direct clinical management of specific conditions. Research-based clinical protocols for nursing practice are not widely developed in Canada. However, many provincial and territorial regulatory bodies issue policies, position statements or directives relating to specific clinical issues, such as cardiopulmonary resuscitation and blood-borne diseases like AIDS or Hepatitis B.

Summary of Regulatory Standards:

- ***One of the precepts of self-regulation in Canada is that the profession sets its own standards of practice. For this reason, the primary legal responsibility for establishing professional, ethical and nursing standards lies with provincial/territorial registering bodies.***
- ***Other regulatory standards which the regulatory body expects members to meet include federal and provincial/territorial legislation, such as the Criminal Code and human rights acts, and standards developed by nonlegislated professional associations, such as the Canadian Nurses Association, which are widely understood and accepted within the profession.***

Provisions for Sanctions of Licensure/Regulation

Source of Complaints

One of the fundamental responsibilities of nursing regulatory bodies in Canada is protecting the public from incompetent and unfit members of the nursing profession and encouraging the provision of high quality nursing care. One means of doing this is through the investigation of complaints that a member has acted incompetently or has breached one of the other standards of the profession. Complaints can come from a member's colleagues (nurses and other health care providers), employer, the patient, the patient's family, or other members of the public.

Formal complaints are generally required to be in writing and to name the nurse who is the subject of the complaint. Historically, the majority of formal complaints have come from other nurses or employers. In the past few years, the proportion of complaints coming directly from the public has increased.

Reports also may be received from nurses or members of the public about individuals who are not registered members of the profession but have been using a title or performing an act restricted to registered members of the profession.

Grounds for Discipline

Breaches of a nursing regulatory standard by a member of the profession can be grounds for discipline of the member. Generally, the regulatory body has no authority over a non-member, although, in a few instances, the registration act gives the regulatory body authority to discipline a non-member for acts that occurred while the individual was a member.

In some cases, non-members who use one of the restricted nursing titles or who perform acts restricted to members of the profession can be prosecuted through the criminal judicial system by the province either directly, or through a complaint by the regulatory body.

How Complaints are Addressed

All regulatory bodies have procedures and time frames for addressing complaints regarding the conduct/practice of a registrant. Some of these may be explicitly set out in the authorizing legislation, and others may be established by the regulatory body itself. Procedures include investigation of the formal complaint by a qualified investigator and independent review by a board or council committee to consider whether the incident surrounding the complaint merits further review.

Typically, the review committee considers only written submissions and documents and does not interview witnesses directly. If the review committee often called a Complaints Committee, determines that a formal disciplinary hearing is required, the matter is referred for a formal adjudicative hearing by another committee (e.g., a Discipline Committee) of the regulatory board or council, to review the matter and consider any penalty.

These adjudicative hearings are conducted in a manner consistent with specific legal procedures established in the nursing legislation and in any general administrative law, including the rules of natural justice, governing the conduct of administrative tribunals. They are formal hearings, subject to many of the rules of evidence and conduct found in a formal trial.

In some provinces, matters relating to mental or physical incapacity, including substance abuse problems, are addressed through a separate committee charged with responsibility for addressing complaints relating solely to incapacity.

The investigation and hearing processes involved in a disciplinary matter are extensive, and can be time consuming and costly for both the regulatory body and the member. Some regulatory bodies have recently begun to use, or to consider using, a process for alternative or expedited settlement. Typically, the kind of complaints that are resolved through this alternative process are less serious, the facts of the case have been admitted, and the member who is the subject of the complaint has consented to the negotiated penalty.

Sanctions

Provinces and territories vary in their procedures for sanction and the penalties imposed. In general, however, all have the authority to impose terms, conditions or limitations on a member's registration certificate/license to practice. These commonly include:

- monitoring by employer and performance appraisals;
- requiring copies of sanction conditions be given to employers;
- requiring treatment and rehabilitation for substance abuse or mental health problems;
- restricting a member from administering or having access to controlled substances, e.g., narcotics;
- requiring a member to complete a refresher or re-entry course;
- requiring a member to practice under direct supervision;
- giving the member a written reprimand or requiring the member to appear before a panel for an oral reprimand; and
- suspending a member's certificate/license for a specified period of time.

The ultimate sanction is permanent revocation of a member's certificate/license. Many jurisdictions also have the authority to impose fines or impose a levy to reimburse the regulatory body for all or some of the costs of the hearing.

Decisions of a disciplinary committee can usually be appealed by the person making the complaint, the member who was charged, or the regulatory body itself, to an independent review board established by the government. Decisions of the review board may in turn be appealed to a provincial/territorial appeal court.

Individuals who are prosecuted in the criminal courts on the grounds that they have used a restricted title or acted as an impostor, are generally subject to a fine, although in extreme cases, a prison sentence also may be a possibility.

Cross Jurisdiction Sharing of Information

National Discipline Database: The National Discipline Database is a project of the Canadian Nursing Discipline Counterparts (CNDC). The CNDC is a network of individuals responsible for the administration of professional conduct review within a framework of self-regulation. They are seeking to create a national database of information on discipline decisions related to RN's made by all the nursing regulatory bodies.

The database (to be implemented in January 1996) is intended to:

- provide national statistics on discipline activities;
- identify trends in complaints and actions;
- provide for analysis of the trends and the formation of policy;
- enhance professional self-regulation at the national level;
- provide a focus for education activities within its jurisdictions; and
- enhance knowledge and expertise in the administration of the discipline process.

In addition to the aggregate data collected through the national database, provinces and territories distribute discipline findings relating to individual nurses, when such findings have been published in the jurisdiction that rendered the discipline.

Summary of Provisions for Sanctions:

- ***Anyone can make a complaint to the regulatory body about the competence, conduct or incapacity of an RN or PN.***
- ***Strict administrative processes and procedures govern the conduct of investigations, adjudications, and the imposition of sanctions in order to ensure that they reflect administrative fairness and rules of natural justice.***

Emerging Trends and Regulatory Issues in Canada

Canada's system of health and social policy programs is under tremendous pressure, due largely to a combination of spiralling costs at a time of large government deficits and fiscal restraint. Provincial and territorial legislation and models for regulating health professions are in varying stages of reassessment and restructuring.

This section gives a snapshot view of some of the major trends and regulatory issues that are expected to have a significant impact on nursing regulation in Canada over the next five years.

Health and Social Public Program Cuts

Strong federal and provincial/territorial government commitments to reducing large fiscal deficits are leading to some of the most drastic cuts and reassessments of social and health programs and policies which Canada has ever seen. Continued political willingness or ability to implement social policies that focus on improving the determinants of health (i.e., health promotion) is uncertain. There are clear indications that the scope of Canada's system of universal and accessible health care is being questioned, and public concern about the outcomes of such questions is widespread. Government strategies to maintain the fundamental core of the system by more stringently defining the "medically necessary" services eligible for public funding are becoming evident.

Reforms of Health Care Delivery System

The search for alternative, cost effective models of delivering and funding health care services is leading to widespread restructuring and rationalization of health care delivery models and to reallocation of health care resources. Drastic cutting of acute care beds, merging or closing of hospitals, and shifting of health care priorities to community and longterm care are occurring. As a result of the pressures to discharge patients from hospital as quickly as possible, the acuity of patients in both acute and community care settings is much greater. Questions about the extent to which nurses have been educated and prepared to perform in these changing settings are being asked.

At the same time, health delivery systems are changing the mix of health care providers hired in efforts to use the most cost-effective providers possible. The replacement of regulated health care providers with unregulated providers is increasing, not only in traditional settings such as longterm care facilities, but also more recently in acute care settings. Such replacement in acute care settings is seen by many nurses as particularly problematic because of the higher acuity levels of acute care patients due to the earlier discharge patterns noted above.

Efforts to use health care dollars more effectively include increasing emphasis on the development of clinical guidelines or standards for physicians and greater interest in the role of the nurse in primary health care. Recognition of the need for research that would support nursing practice using outcomes-based approaches, i.e., evidence-based practice, is also growing.

Efforts to Undertake Human Resource Planning[10]

Historically, health human resource development [in Canada] has occurred on an ad hoc, cost driven basis. Over the last decade, initiatives and research centres across the country have been attempting to identify how certain health care providers contribute to funding pressures on

the system, and to build a body of statistical research and forecasting models that will assist public policy makers in planning for the "right" number and mix of health care providers. By far the largest proportion of this work has focused on physician planning. For example, in 1990, the federal and provincial/territorial Ministers of Health initiated a collaborative national physician action plan. The Ministers asked the question whether "...planning [should] be done at a profession-specific level or through an integrated model which looks at health human resource planning overall".

Issues stemming from the lack of integrated health human resource planning include:

- limited linkages among public policy, health system planning and health human resources development;
- fragmented responsibility for health human resources development among local, provincial/territorial and federal governments;
- lack of research on health indicators and determinants of health;
- rigid scopes of practice and roles of providers in some jurisdictions;
- competition among existing health provider groups;
- restrictive regulation and accreditation processes;
- traditional labour practices and methods of funding and remuneration;
- lack of consistency in portability of the credentials of providers across provinces; and
- current discipline-focused education models.

Public Demands for Participation and Accountability

The Canadian public is better educated about health care issues, but at the same time is more demanding of its rights to make autonomous decisions about its own health care and about its rights as a consumer. Public demand to have greater choice over the type of health provider available and to have rights to informed decision honoured is increasing. Ethical and legal issues are abounding and include such issues as consent to treatment, the right to make advance directives concerning treatment, decision making on access to limited and/or costly treatments, and euthanasia.

A substantive proportion of the Canadian public is aging and anticipates making increasing demands for health care services. This population wants to participate in the public policy choices identifying what services will be defined as "medically necessary" for public funding purposes.

Regulatory Issues for Nursing

A myriad of issues about the regulation of health care professionals generally, and nurses in particular, has arisen from this complex and dynamic environment, including:

- The emerging view that professional regulation must take a more comprehensive approach to build on and enhance the quality of services provided by the profession.
- The need to evaluate the effectiveness of existing regulatory mechanisms for ensuring that nurses have the knowledge, skills and attitudes to perform safely and effectively in the changing health care environment. Continuing competence, continuous quality improvement, quality assurance, and lifelong learning have become common regulatory buzz words. Ongoing issues include whether baccalaureate entry to practice should be mandatory and whether to have special regulation for advanced nursing practice and nursing specialities.
- The need to assess the extent to which scope of practice models may unduly restrict nursing from responding to the changing health care environment and public needs.
- The need to address the impact of issues such as multiple accountabilities and competition, which are arising out of changing relationships among health care professionals, and the need to assess the obligations and accountabilities of nurses working with unregulated health care providers.
- The assessment in some of jurisdictions of whether to develop omnibus regulatory legislation, either for health professions specifically or for general professions, and whether to separate the regulatory and professional functions now combined by most of the provincial/territorial nursing associations.

Another emerging and sensitive issue for nursing regulatory bodies is the assessment of whether they have a role in identifying when patient loads, acuity levels, and health care provider mixes compromise the individual nurse's ability to provide safe and effective care, and if so, what is that role.

Footnotes

1 This category has different titles depending on the province - Licensed Practical Nurses, Registered Nursing Assistants, Registered Practical Nurses, and Certified Nursing Assistants. For ease of reference, the term "practical nurse" is used throughout this paper to refer to all of these terms.

2 Registered Psychiatric Nurses are only found in the four western provinces of British Columbia, Alberta, Saskatchewan and Manitoba. They are not specialized RN's. They study a separate educational program focused specifically on psychiatry and are regulated by an association that is independent of the RN regulatory body.

3 Statistics, Canada, Health Statistics Division, Registered Nurses Management Data, 1994. These figures are based on those nurses who are seeking renewal of their registration or licensure, and do not include nurses whose registration has lapsed.

4 Canadian Nurses Association, 1994 Canadian Nursing Statistics Highlights, Research Department, January 1995.

5 Canadian Association of Practical Nurses, 1994 Annual Report.

6 When the patient or client's condition is common enough that the outcome is predictable, allowing the PN to implement pre-set care plans that include a limited range of interventions.

7 The Canadian Nurses Association, the national umbrella association for the professional associations, provides certification in nursing specialties. Certification is currently given in seven specialties: neuroscience, occupational health, nephrology, emergency, critical care, psychiatric/mental health, and perioperative nursing.

8 This paper has followed the general rule that it is describing regulation or licensure of nursing in Canada in the period March to August 1995. However, because the norm-referenced examination is being replaced, the remainder of this section describes the new criterion-referenced exam.

9 Alberta is an exception. In Alberta, the examination is administered by the Universities Coordinating Council. Approval to register for the examination for foreign education applicants is given by the Alberta regulatory association.

10 This section has drawn particularly on a paper prepared on behalf of a coalition made up of the Canadian Association of Occupational Therapists, the Canadian Dietetic Association, the Canadian Nurses Association, and the Canadian Physiotherapy Association - McKay, Nancy E., Pragmatism or Pie in the Sky? Integrated Health Human Resources Development National Draft Framework for Discussion, January 1995.

Appendix A

Requirements for Initial Registration as an RN in Canada

Applicants for registration as a registered nurse in any Canadian province or territory in Canada must:

1. Pay the registration fee.
2. Provide proof of legal name (except in Ontario).
3. Have graduated from a nursing education program approved by the province or its equivalent.
4. Have been registered by examination (see below for details) and must have been a member in good standing in the jurisdiction where the original nursing education took place and where the applicant last practiced, if the applicant is applying to a province from another jurisdiction.
5. Provide evidence of recent practice or recent study of nursing (details vary with each province).

Over and above these common requirements, individual provinces have imposed additional entry to practice requirements.

Additional Requirements by Province/Territory

Province/ Territory	Exam Requirements	References	Character Requirements	Language Requirements	Other Requirements
Alberta	CNATS, SBTPE or the requirements in another Canadian jurisdiction.	Must have satisfactory nurse employment references if employed in another jurisdiction.	Must be of good character.	Must demonstrate competency in English.	n/a
British Columbia	CNATS, SBTPE or the requirements in another Canadian jurisdiction.	Must give consent for previous employers to be contacted for references.	Must be of good character and not have a criminal conviction relevant to nursing.	Must demonstrate competency in English.	n/a
Manitoba	CNATS, SBTPE or the requirements in another Canadian jurisdiction.			Must demonstrate competency in English.	n/a
New Brunswick	CNATS, SBTPE or the requirements in another Canadian jurisdiction.	Must submit written references or employment references as required.	Must be of good character.	Must demonstrate competency in either English or French.	If applicant has not worked in North America, he/she must complete a supervised clinical experience.
Newfoundland	CNATS, SBTPE or the requirements in another Canadian jurisdiction.	Must have satisfactory references.	Must be of good character and not have a criminal conviction relevant to nursing.	Must demonstrate competency in English.	n/a
Nova Scotia	CNATS, SBTPE	Must have satisfactory nurse employment references.	n/a	Must demonstrate competency in English.	n/a

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Appendix A: Requirements for Initial Registration as an RN in Canada (continued)

Province/ Territory	Exam Requirements	References	Character Requirements	Language Requirements	Other Requirements
Ontario	CNATS, or equivalent.	Must have satisfactory nurse employment references.	Must be of good character and not have a criminal conviction relevant to nursing.	Must demonstrate competency in English or French.	Canadian citizenship, permanent residency, or authorized by the Immigration Act to practice nursing.
Prince Edward Island	CNATS, SBTPE or the requirements in another Canadian jurisdiction.	Must have satisfactory nurse employment references.	Must not have a criminal conviction relevant to nursing.	No language requirements.	n/a
Quebec	CNATS, SBTPE		Applicant must not have been found guilty of a criminal offense related to the practice of nursing unless he/she has obtained a pardon. Must not have been subject of a disciplinary decision imposing a revocation or limitation of the registration certificate.	Must demonstrate competency in French.	Supervised clinical training if no experience in North America. Canadian citizenship, permanent residency.
Saskatchewan	CNATS, SBTPE or the requirements in another Canadian jurisdiction.	Must be able to provide references as required.	Must be of good character and not have a criminal conviction relevant to nursing.	Must demonstrate competency in English.	n/a
Northwest Territories	CNATS, or the requirements in another Canadian jurisdiction.	Must have satisfactory nurse employment references.	Must be of good character and not have a criminal conviction relevant to nursing.	Must demonstrate competency in English (policy not legislation).	n/a
Yukon	CNATS, or the requirements in another Canadian jurisdiction.	Must have satisfactory nurse employment references.	Must be of good character and not have a criminal conviction relevant to nursing.	Must demonstrate competency in English.	n/a

Licensure/Registration of Nurses and Standards of Practice in Mexico

Lic. Silvia de la Fuente Rocha
Colegio Nacional de Enfermeras, A.C.

Executive Summary

The first section of this chapter covers the origin of licensure, as well as Mexico's form of government, demography and geography. A description of the laws providing for the regulatory issues of nursing practice is also included. In addition, the National Health System is described, including its current status and its future as outlined in the 1995-2000 National Development Plan. Labor-related issues, as provided by the Federal Labor Law, are also considered.

Reference is made to the historical and social issues affecting nursing that date to the pre-Colombian era when the Tlamatqui-ticitl (lay midwives) took care of pregnant women from the time of their first symptoms. These were the first indications of the important role played by these women.

The first section of the chapter also describes the National College of Nurses (Colegio Nacional de Enfermeras, or CNE), which has played an important role in fostering the professional development of nursing since its creation in 1947. The CNE organized the state nurses associations and promoted the creation of the Association of Nursing Schools in 1967, known today as the National Federation of Associations of Nursing Schools (Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería, or FENAFEE). The CNE has conducted several other nationwide activities, such as the National Census of Nursing Human Resources and the Regulation Project for the teaching and professional practice of nursing. It has recently integrated the National System for Accreditation and Certification in Nursing (Sistema Nacional para la Acreditación y Certificación de Enfermería, or SNACE).

The second section of this chapter focuses on the process of granting licenses, including the legal foundations, the prerequisites and the responsible government agency. Reference also is made to the maintenance of a continuous competence level. The internal mobility of nurses and the mobility of foreigners is described, although the latter has not been significant to date.

The third section deals with regulatory standards, including the legal entities regulating and penalizing poor practice, the self-regulating ethical standards, and the standards promoting personal responsibility. While nursing regulations have been drafted, they have not yet been approved. However, health care standards have been developed by nurses at each health care institution. A brief description is given of the penalties for poor practice, according to the seriousness of the consequences to the patient.

Finally, regulation trends for nursing in Mexico are described. The CNE is devoting a great deal of effort to

the improvement of nursing quality standards, the improvement of health care quality through the establishment of standards regulating teaching and professional practice, and the improvement of the continuous level of competence of nurses.

Factors That Have Shaped Licensure/Registration

Government

Mexico is a representative, democratic federal republic consisting of 31 states and the Federal District, which is located in Mexico City. This is the capital city of Mexico and is the location of the three branches of the federal government.

The highest law is the *Political Constitution of the Mexican United States.* It contains the highest principles governing and protecting human rights, the national sovereignty, the republican system, and the division of powers for the purpose of guaranteeing freedom, democracy and social justice for all Mexicans.

The federal government is divided into three branches: the legislative, the executive and the judicial branch. The public administration is centralized and run by the federal government. The 31 states and the Federal District are independent in terms of their internal regimes. They are governed by their own constitutions that are in hrmony with the *Political Constitution of the Mexican United States,* and have adopted a representative, republican form of government.

The President of the Republic is elected through universal sufferage for a six year term without the possibility of reelection. The President has the authority to appoint first-line officials, i.e., Secretaries of State, one of which is the Secretary of Health.

Origins of Nursing Regulation

The regulation of the professional practice of nursing is originated from Article 5 of the Constitution. This Article is the source for the laws and regulations published in the Law on Professions of the Public Education Secretariat (Secretaría de Educación Pública, or SEP). The profession of Nursing and Obstetrics was included in this law in 1945, by presidential decree. This law established the compulsory registration and issuance of a license (cédula) for nursing professional practice.

The Public Health Secretariat (Secretaría de la Salud Pública, or SSA) also established a voluntary record of professional practitioners in the health care field. However, this record was discontinued in 1985 due to the low number of practitioners registered.

Summary:

- ***The Mexican Republic consists of 31 states and the Federal District. It is governed by a Political Constitution. Its government is divided into three branches: legislative, executive and judicial. Its administration is centralized and controlled by the federal government.***
- ***The states are independent and governed under the principle of a representative republican government.***
- ***The origins of the professional practice of nursing are found in Article 5 of the Constitution. The profession of nursing and obstetrics was included in the General Law on Professions in 1945 and registration became compulsory.***

Geography

Mexico has a total land area of 1,958,201 square kilometers. The continental area is 1,953,128 square kilometers and the islands comprise 5,073 square kilometers. In terms of geographical size, Mexico is the fifth largest country in the Americas, surpassed only by Canada, the United States, Brazil and Argentina, and the 14th-largest country in the world. The Mexican Republic is bordered on the north by the United States of America, on the east by the Gulf of Mexico and the Caribbean Sea, on the southeast by Belize and Guatemala, and by the Pacific Ocean on the southwest.

Demography

According to the 1990 census, the total population of Mexico is 81,249,645. The Federal District has the highest population density because of the population residing in the surrounding urban area of the State of Mexico. The state with the lowest population density is Baja California Sur. Data from the 1990 census show that 71 percent of the population is concentrated in the urban areas, while 29 percent lives in rural areas.

The life expectancy at birth is 67.1 years. The largest population group is comprised of those under 15 years of age, accounting for 37.5 percent of the total population.

Mexico has 56 ethnic groups distributed in 24 states. All of these groups speak their own dialects, though the country's official language is Spanish.

As of 1994, nursing personnel were distributed as follows:

Personnel	Subtotal	Percent	Registration or License
Bachelor's in Nursing	5,592	3.0	5,592
General/ Technical Nurses	115,762	63.0	115,762
Auxiliary nurses (Nurse's Aides)	63,604	34.0	No registration
Total	**184,958**	**100.00**	**121,354**

Source: General Directorate of Professions Report 1994. Statistical Information Bulletin #14-1994.

Women have always been more prevalent in nursing, with men comprising only about one percent of pratictioners.

Summary:

GEOGRAPHY: Mexico ranks as the 5th largest country in the Americas. To the north, it borders on the United States and to the south on Guatemala and Belize.

DEMOGRAPHY: The total population of the country is 82,249,645. The Mexican population is young, with 37.5 percent under the age of 15.

The total number of nurses is 184,958, 66 percent of whom have a license or registration to practice the profession.

National Health System

The National Health System coordinates the health programs conducted by the federal government with those conducted by the state governments, as well as with the social and private sectors involved in health care. This activity is aimed at providing the population with access to health care services. The coordination activities are the responsibility of the Public Health Secretariat.

The National Health System has three components:

1. Health care entities for which the system is compulsory.
2. State governments linked with the federal government.
3. Social and private sectors.

The General Health Law defines the functions, responsibilities and authority granted to the entities forming the Health Sector and the National Health System. According to the data from the National Statistics, Geography and Information Institute (Instituto Nacional de Estadistica, Geografia e Informatica, or INEGI), the population served by the Health Sector is as follows:

Institution	Population
Public Health Secretariat	27,926,000 people
ISSSTE*	8,642,852 insured people
IMSS**	37,464,560 insured people
PEMEX***	836,474 insured people
National Defense Secretariat	798,852 insured people
Navy Secretariat	151,059 insured people
DIF****	2,421,160 people
Others	3,008,688 people

* ISSSTE: Government Workers Social Security and Services Institute (Instituto de Seguridad Social al Servicio de los Trabajadores del Estado)

** IMSS: Mexican Social Security Institute (Instituto Mexicano del Seguro Social)

*** PEMEX: National Petroleum Corporation (Petroleos Mexicanos)

**** DIF: Integral Development System for Families (Desarrollo Integral de la Familia)

The budget for the health care system as a percentage of the Gross Domestic Product was 2.7 percent in 1991, 3.5 percent in 1992 and 3.4 percent in 1993.

Perspectives

The current administration has established health policies in the 1995-2000 National Development Plan. The largest challenge is to grant the entire population access to health care services and to improve their quality. Despite the progress made in health care services, regular access to such services is not yet a reality for all Mexicans. There are still some regional inequalities, marginalization and poverty that combine with health problems and social and economic crises.

Reform of the National Health System is aimed at:

- improving the quality of health services;
- expanding health services coverage to the less privileged population;
- transferring health services to the states;
- reorganizing the health care budget; and
- guaranteeing an optimum level of preparation of health care personnel, with special emphasis on physicians and nurses.

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Summary:

The National Health System and the Health Sector are coordinated by the SSA. The health care budget as a percentage of the GDP for 1993 was 3.4 percent. The health policies set forth in the 1995-2000 National Development Plan include:

- ***Reform of the National Health System.***
- ***Expansion of health services coverage.***
- ***Transfer of health services to the states.***
- ***Reorganization of the health care budget.***
- ***A guaranteed optimum level of training of health care personnel.***

Labor Issues

Labor issues are regulated by the Federal Labor Law that stems from Article 123 of the Constitution. Section A of this law provides for "a general labor contract for all workers, the general working conditions that apply to each area or profession and the type of institution in which they work." Some examples include:

- The maximum duration of the working day will be eight hours.
- A night labor shift will be seven hours.
- Pregnant women will not perform any effort-intensive job that may endanger their health. They will be entitled to a leave of absence period of six weeks prior to the likely delivery date and another six weeks after such date. They shall also be entitled to receive their full wage and to keep their jobs. During their nursing period, they shall be entitled to two extra 30-minute breaks per day.
- There are two kinds of minimum wage: general and professional, which differ by areas of economic or professional activity.
- An equal wage shall correspond to an equal job, regardless of sex or nationality.

Section A also provides for labor risks, for penalties and warnings, and for benefits, such as vacations, seniority, promotions and retirement. Most important, it provides for mandatory continuing education programs to be offered to employees by their employers.

Historical and Social Issues

The Tlamatqui-ticitl (lay midwife) played a central role in the Aztec community. She was in charge of caring for pregnant women, attending at the delivery, and caring for women during the puerperium. She also cared for newborns. In the pre-Colombian era, over 1,200 medicinal plants were used and their hemostatic, antispasmodic and analgesic properties were widely known. The Spanish conquerors were impressed by the efficiency of some native medicines and made efforts to learn more about them. The conquerors also brought along a midwife to take care of the injured in Zempoala and Cholula during the Conquest battles.

The Imaculada Concepcion Hospital, today known as Hospital de Jesús, was founded in 1524, three years after the fall of the city of Tenochtitlan. Sixteen other hospitals were opened in Mexico City and 74 others in various parts of the country in later years. Outstanding among those was the San Hipolito Hospital for mental patients, one of the first of its kind in the world. Various religious orders took care of the sick, while "nurses" were in charge of providing first-aid care in hospitals and jails. These nurses were mature women, "decent" single women or widows, whose job was considered so humble that they were not required to obtain a license to practice.

No mention is made of the role of nurses during the War of Independence in 1810. Only two women are cited for providing outstanding care for the sick during that war, Doña Josefa Ortiz de Dominguez and Doña Leona Vicario. During the American invasion of Mexico in 1847, the civil population joined forces to support the Mexican army. Hospitals were provided with the necessary supplies, and nuns and a group of young nurses took care of the injured. Early in 1915, during the Mexican Revolution, the Bajio region was practically covered with the blood of hundreds of injured people begging for care. Mexican nurses entered the battlefields trying to look after the fallen. They endured thirst, hunger and sleeplessness. After 18 months of traveling 10,000 kilometers on railways across the country, these Mexican nurses returned to Mexico City at the end of the Revolution. Their tasks were then absorbed by the Military Hospital.

Late in the 19th century, there were some training courses for nurses. Students were given uniforms and equipment, and they conducted their practice with outpatients and at hospitals. In 1900, Dr. Eduardo Liceaga asked President Porfirio Diaz for authorization to open a nursing school in Mexico. The curriculum at that school lasted two and a half years and the entry requirement was at least four years of elementary school.

Following the founding of the General Hospital in 1907, and in view of the need for trained staff, the profession of nursing was created. Dr. Liceaga said, "The nursing school can be considered not only as a benefit for the sick who come to this hospital looking for a cure, but as a powerful factor for the dissemination of useful knowledge for women who have chosen this profession. This school

was created with the sole purpose of training and educating nurses for the General Hospital, as this hospital meets all the requirements for teaching. We hope that the government may support and improve the nursing school not only for the benefit of this hospital but also to provide home assistance by trusting to the experts the health care that is only furnished today by loving hands."

Students who successfully completed the three-year program were granted a diploma from the General Public Welfare Directorate (Dirección General de Asistencia Pública). The diploma was proof of completion of the studies and of the grades obtained by students.

In 1910, nursing education was entrusted to the National School of Medicine. In 1936, the Secondary Education Certificate became a requirement for those enrolling in nursing studies. In turn, the nursing degree was necessary to gain access to the obstetrics program.

In 1945, the nursing program became autonomous and changed its name to the National School of Nursing and Obstetrics (Escuela Nacional de Enfermería y Obstetricia). Also that year, some nursing service directors were chosen and appointed as instructors for the school. In addition, the profession of Nursing and Obstetrics was included in the General Law on Professions in 1945. This meant that nurses had to obtain a license (cédula) to practice their profession.

In 1960, a study was conducted to promote the opening of nursing schools in the Mexican provinces by providing technical and financial aid. In 1966, some nursing schools began to require candidates to have a senior high school certificate as a condition for entrance.

From 1900 to 1929, health education activities were expanded. A six-month preparatory program for visiting nurses also was initiated during that period. The program of Public Health Nursing, with a duration of one year, was initiated in 1949. Other specialty programs also were created, such as Pediatric Nursing (1941), Nursing Education (1952), Psychiatric Nursing (1953), Surgical Nursing (1954), Nursing Services Management (1955), and Obstetrics and Nursing Instructor (1964).

Public health nurses made a great impact on the organization of services at the Health and Assistance Secretariat. Some structure was given to the organizational and functional management of nursing services at the national (central), state, district and local levels. The service of visiting nurses was organized, and a pilot center for the training of department heads, supervisors, nurses working in the Mexican provinces and nurses from some Latin American countries was created. In this way, health services were taken to the rural areas, thus raising health coverage levels and cutting down on morbidity and mortality rates. An example of this improvement in health care delivery was the eradication of smallpox.

National College of Nurses (Colegio Nacional de Enfermeras, or CNE)

In 1946, a group of visionary nurses realized the importance of creating an association of nurses, that is, a nongovernmental organization that would promote the improvement of the nursing profession in Mexico. The proposal was welcomed by nurses, and some heads of departments were entrusted with the implementation. In 1947, the Mexican of Nurses Association (Asociación Mexicana de Enfermeras, or AME) was founded, and by 1955, it had representatives across the country. AME became a member of the International Council of Nurses (ICN) in 1961; 12 years later, Mexico was host to ICN's 15th Quadrennial Congress. Also in the 1970's, the organization of the states' affiliate associations was initiated. The *Enfermeras* magazine began to be published at that time, but due to a lack of resources, the magazine has not been published regularly. Nonetheless, this magazine has been an instrument for the dissemination of the academic and professional activities of nurses in Mexico, as well as technological advances and the nursing profession in other countries. *Enfermeras* has also contributed to disseminating information sent by the ICN on a continuous basis.

AME changed its name to National College of Nurses, A.C., (Colegio Nacional de Enfermeras, or CNE) in 1966 in order to broaden the expectations of nursing and to gain some legal support for professional nurses. In this way, the scope of action of the association was expanded by also including activities established by law.

In 1967, the CNE created the National Association of Nursing Schools, today known as the National Federation of Nursing Schools (Federación Nacional de Asociaciones de Facultades y Escuelas, or FENAFEE). In 1970, the First National Census of Nursing Resources was conducted jointly by CNE and the health institutions. The second census was conducted in 1992 with the financial support of the Canadian Nurses Association. So far, the CNE has organized 11 national congresses, and has participated in national and international events. It has been concerned about the academic and professional development of nurses and has organized several courses. The CNE also has organized some related activities, such as the Nursing Regulation Project, and is currently working to establish the National Nursing Accreditation and Certification System (Sistema Nacional de Acreditación y Certificación de Enfermería, or SNACE).

Summary:

- ***Although nursing in Mexico has made progress throughout history, some of its goals have not yet been attained. Thus far, it has had limited participation in decision-making processes.***
- ***The evolution of nursing has been slow but positive. The profession has had an important, positive influence on public health.***
- ***The CNE has influenced the nursing profession in Mexico since 1947 both in the academic area and the organization of state associations and the FENAFEE. Currently, it is working to create SNACE.***

Current Status of Licensure/Registration

Locus of Authority for Nursing Regulation

Government authorities are responsible for the regulation of professional practice. The General Professions Directorate (Dirección General de Profesiones, or DGP), an entity of the SEP, is in charge of keeping records of school degrees and granting the professional practice license (Cédula Professional). There are similar entities in several states. In states where there is not a license-granting entity, school graduates must travel to Mexico City to obtain their license.

Laws and Processes of Origin

The license for the professional practice of nursing originated in 1945 when the profession was included in the General Law on Professions. This law stems from Article 5 of the Constitution and makes reference to the following issues.

Chapter II. Article 8. Requirements to be Met for Granting a Professional Degree

To obtain a professional degree, graduates must show evidence of having complied with the academic requirements set forth by the applicable laws.

This means that nursing students graduating from the technical and baccalaureate levels must show evidence of having passed all subjects in their three- or four-year curricula, respectively; of having completed their community service; and of having passed their professional examination. This examination is taken by students, in groups or independently, upon completion of their community service, and it varies according to the regulations of the individual schools.

If students choose to take an individual examination, they must prepare a thesis under the guidance of an advisor. Their examination consists of two sections, one oral and one practical. The oral examination is taken before three examiners appointed by the academic department to which the thesis is submitted. The questions posed to the degree candidates are based on the subjects included in the school curriculum and are also related to the thesis topic. The practical examination is taken at a hospital, with the department and patient chosen by the examiners. Once the two parts of the examination are completed, the examiners take a vote on passing or failing the candidates. If all three examiners cast a passing vote, candidates are considered unanimously approved; two votes constitute approval by a majority. Candidates are considered to have failed the examination with two failing votes from the examiners. Failing students are given two further opportunities to take this examination.

The group examination consists of a written exam whose content is divided into areas of knowledge. This exam is prepared by teachers of the nursing schools. It consists of 1,000 questions and students are given eight hours to complete it. It is graded on a scale of one through ten, with a minimum passing grade of seven.

Once successful candidates are given their degree, they are responsible for applying for their license (cédula) with the DGP.

Chapter IV. Article 23. The General Professions Directorate (DGP) is authorized to:

1. Register professional degrees referred to by law.
2. Issue a license (cédula) by which the holder is allowed to practice his/her profession and by which the holder will be identified in all professional activities.

The following documents must be attached to the license (cédula) application:

- Photocopy of the community service certificate.
- Photocopy of the letter stating that the school curriculum has been successfully completed.
- Certificate of professional examination.
- Original birth certificate.
- Three license-size photos.
- Six record card-size photos.
- Voucher for duties paid for degree registration and issuance of the license (cédula). Duties must be paid at any branch office of the Treasury Secretariat.

Chapter V. Article 25. For an individual to practice any technical or scientific profession, he/she must:

1. Be Mexican by birth or naturalization and be fully eligible to exercise his/her civil rights.

2. Hold a degree legally issued and registered.
3. Obtain a license (cédula) from the DGP.

This procedure is still in place today as the professions are not yet self-regulated. However, the North American Free Trade Agreement (NAFTA) has opened a window of opportunity to analyze and review the laws, to support professional associations, to improve the quality of services, to be self-regulated and to control professional practice.

General Law on Health

The General Health Law (Title IV, Chapter I, Article 78) specifies that the practice of professions' technical and auxiliary activities related to health care shall be subject to the following:

1. The Regulating Law of Article 5 of the Constitution.
2. The coordination basis to be defined between education and health authorities.
3. The provisions of this law and related applicable legal standards.
4. The laws issued by the states based on Article 5 of the Constitution.

Nature and Structure of the Regulatory Body

Thus far, government bodies, federal government agencies the SEP and the SSA have been in charge of regulating the practice of the profession.

Defined Levels

The levels existing in nursing for practice at health institutions are the following:

Level	Education
Bachelor in Nursing	12 years of basic education 4 years of nursing preparation 1 year of community service Nurse degree BN license
Technical or General Nurse	9 years of basic education 3 years of nursing preparation 1 year of community service Nurse degree Nursing license
Auxiliary Nurse (Nurse's Aide)	6 years of basic education 1 years of nursing preparation Auxiliary Nurse credential

Entry Level Requirements for Nursing Practice

Examination

Nature and structure of the examination

Health care institutions employing nurses "certify" *de facto* the level of competence of the nursing staff. This certification is mainly based on the training requirements defined by the position to be filled. Candidates take an examination, and human resources departments hire the staff based on their qualifications and examination results. For example, the requirements for a nursing supervisor position are:

- Nursing degree legally issued by an officially acknowledged school;
- Nursing license (cédula);
- Academic transcripts and nursing experience; and
- Passage of examination on theoretical issues related to the position to be filled.

License (Cédula)

Renewal/Continuance

In Mexico, there is no specific license (cédula) renewal policy. Licenses are granted once and can be cancelled only if the holder breaches any law regulating his/her profession.

Re-entry

One limitation for re-entry is the lack of available positions at the time the application is submitted. Another limitation is being over 35 years of age.

Continuous Level of Competence

While there are no periodic assessments aimed at determining the nurse's level of competence, the Federal Labor Law provides for the proper training and education of workers (Chapter III Bis). Specifically, all workers are entitled to training and education for the job they perform in order for them to improve their standards of living and productivity. The training programs shall be drafted by common consent between the employer and the labor union or workers themselves, and shall be approved by the Labor Secretariat (Article 153-A).

Training and education shall be aimed at:

1. Updating and improving the knowledge and skills of workers and providing them with information on the application of new technologies;
2. Preparing workers to fill vacancies or newly created positions;
3. Avoiding labor risks;

4. Increasing productivity; and
5. In general, improving the worker's skills (Article 153-F).

Workers attending the training or education sessions are bound to:

1. Be on time for the courses, group sessions and related activities included in the training and education program;
2. Follow the directions of the course instructors and complete the relevant programs; and
3. Take the required examinations designed to assess their knowledge and skills acquired (Article 153-H).

Should a worker refuse to attend a training course, stating that he/she has sufficient knowledge to fulfill his/her responsibilities and those of a higher position, he/she shall show written evidence of those skills and shall take an examination before a training agency appointed by the Labor Ministry. If successful, the worker will receive the relevant Labor Skills credential (Article 153-U).

The General Law on Health provides for education, training and updating of the worker's skills (Chapter III). Specifically, the educational authorities, in coordination with the health authorities and with the participation of the higher education institutions, shall propose standards and criteria for the education of health care personnel. The health authorities, without infringing on the scope of action of the education authorities and in coordination with them and with the participation of health institutions, shall set standards and criteria for the training and skills-updating of health care personnel (Article 89).

The SSA and the governments of the states, within their relevant scopes of action and without infringing on the responsibilities of the education authorities and in coordination with them, shall:

1. Promote activities aimed at the education, training and skills-updating of health care personnel;
2. Support the creation of centers for training and skills-updating of health care personnel;
3. Make their facilities available to those institutions, the purpose of which is to teach, train and update the skills of health professionals, technicians and auxiliaries according to the standards governing those facilities (Article 90).

However, the laws make no provision as to the frequency and compulsory nature of the updating courses for practicing professionals. Therefore, there is no subsequent, periodic and systematic assessment to control the continuing competence that guarantees the quality of nursing services.

Mobility

Internal

There are no restrictions on practice anywhere in the country regardless of the school granting the degree. Any individual possessing a degree issued by an officially recognized school and a license (cédula) may apply for a job in any state of the Mexican Republic.

Foreigners

The Law on Professions included in the Regulatory Law of Article 5 of the Constitution, Chapter III, Section III, provides for the registration of degrees issued abroad:

1. Foreigners may practice in the Federal District those professions covered by the law according to the provisions of international agreements of which Mexico is a member. If such an agreement does not exist, the professional practice of foreigners shall be subject to reciprocity in the country of origin of the applicant and to compliance with other requirements set by Mexican laws (Article 15).

2. The degrees issued abroad shall be recorded by the SEP, provided the curricula covered by such degrees are equal or similar to those offered by the institutions comprising the national education system (Article 17).

Immigration does not pose a problem in this respect, since few foreigners work in health institutions.

Summary

- ***The nursing license (cédula) is granted by the federal government through the DGP, which is a branch of the SEP. Self-regulation does not yet exist.***
- ***The professional practice license was created in 1945 when it was included in the General Law on Professions, which derives from Article 5 of the Constitution.***
- ***The levels of nursing in Mexico are: Nurses Aide, General Nurse and Bachelor's in Nursing.***
- ***The requirements for professional practice are: a degree legally issued by an officially recognized educational institution, professional practice license, academic and nursing practice transcripts, and a selection examination with a passing grade.***
- ***Health institutions "certify" de facto the level of competence of their staff and are in charge of keeping it updated.***
- ***The professional practice license is granted once and requires no renewal. There are no restrictions on reentry. The only possible limitations are the lack of positions or that the candidate is over 35 years of age.***
- ***There are no obstacles to internal mobility. The license is recognized in all 32 states of the country.***
- ***The mobility of foreigners is also regulated by the Regulatory Law of Article 5 of the Constitution. The DGP is in charge of supervising its compliance.***

Regulatory Standards

Definition and Emphasis on Regulation

Regulation is understood as a set of rules and legal measures governing the acceptable conduct contributing to the balance and proper functioning of the individual in society. Penalties are applied in cases of breach of regulations.

Sources

Government (Penal Code)

The sanctions for poor practice are general in nature for professionals and are provided for in the Penal Code. For example, sanctions apply:

- To anyone who administers to another individual a narcotic either by inhalation, injection, ingestion or by any other means without a prescription from a legally authorized physician (Article 197).
- To anyone who reveals confidential information without any cause and to the detriment of third party and without the consent of third party who could be affected (Article 210).
- To anyone committing a crime against the life and physical integrity of an individual, such as injuries, abortion, or the abandonment of an individual (Article 291).
- To anyone knowingly assisting or cooperating in any way with the perpetrator of any crime (Article 400).

Regulatory Body (Administrative Regulations)

The General Professions Directorate (DGP), a branch of the SEP, is in charge of regulating the practice of professions. Chapter VIII refers to the crimes and violations committed by professionals, with the penalties referred to in Articles 61 through 73:

- Claiming a professional degree without having a legal degree.
- A degree without the requirements established by the law.
- Crimes committed by professionals in the practice of their profession are disciplined by the Penal Code.
- Individuals will not be allowed to charge fees if they do not register their degree with the proper authorities and obtain their professional practice license.
- The registration of professional degrees will be cancelled if errors or false declarations are found.

Chapter IV of the Federal Labor Law provides for the termination of labor relations with no responsibility for the employer, when an employee:

- Shows false certificates to the employer or the labor union.
- Displays lack of integrity or honesty; takes part in acts of violence, or insults the directors or administrative staff of the institution during working hours.
- Commits any violation against any co-worker.
- Discloses secrets. Refuses to take preventive measures.
- Commits other violations (Article 47).

These laws provide for the type of penalty for professionals who transgress them, according to the seriousness of the violation.

Self-Regulation

1. *Personal responsibility*

   The personal behavior of nurses is regulated by a code of ethics. While nurses do not have their own code of ethics, they have adopted ICN's code of ethics. During their education, nurses are taught the ethical, moral and social values necessary to make decisions in situations affecting the integrity and well-being of the individual, the family and the community.

2. *Collective Responsibility of Professionals*

   The CNE, in coordination with the 32 state colleges, has drafted "Regulations for Nursing", under the guidance of ICN. Provisions are made for the regulation of nursing education and professional practice. This regulation is pending approval from the relevant authorities.

Types

General Professional Standards

These are included in the general labor conditions of each health institution in the chapters on rights, obligations and sanctions.

Nursing Standards

These are drafted by nurses in each health institution, whether public, private or social. As the largest health care institutions in the country, the SSA, the IMSS and the ISSSTE issue some national standards. These standards are aimed at regulating the individual's conduct in the various areas of service, including administration, organization and functioning of nursing services, management of care, nursing processes or models, and clinical techniques and procedures.

Provisions for License/Registration Penalties

Sources of Complaints

Patients and relatives often complain about poor service, long hours of waiting, despotism and poor practice as injurious to patients. The CNE also has filed complaint before the DGP about the use of false degrees and about the dissemination of a distorted image of nurses through the mass media.

Disciplinary Bodies

The type of disciplinary agency appealed to by patients or relatives is determined by the type of violation. The employer may exert some administrative disciplinary measures in case of unjustified absences, lack of discipline in the workplace, and similar infractions.

Legal discipline is provided by the criminal code for negligence, lack of experience, or poor care resulting in serious harm to the patient. Nurses may lose their license (cédula) if they commit a serious violation.

Licensure/Registration of Nurses and Standards of Practice in the United States

Jennifer Bosma, PhD
National Council of State Boards of Nursing

Carolyn Hutcherson, MS, RN
National Council of State Boards of Nursing

Cheryl Peterson, MSN, RN
American Nurses Association

Sally Ruybal, PhD, RN
National Association of Hispanic Nurses

Executive Summary

The foundation of nursing regulation in the United States is the duty of government to protect the health, safety, and welfare of its citizens, as established in the Constitution. In the United States, the states retain any powers not specifically reserved for the federal government, including the regulation of the professions. The regulation of nursing is carried out primarily through administrative agencies of state/territorial governments.

The diverse geography and demography of the United States present unique challenges for assuring access to quality, competent health care services. The nursing profession and nursing regulation also have been shaped by societal issues such as women's and labor movements, by historical events such as wars and changes in higher education, and by economic issues such as shortages of nurses and changes in the financing of health care.

Each state's Nurse Practice Act is the foundational law for the regulation of nursing practice in that jurisdiction. The Nurse Practice Act authorizes an administrative agency of the state government (usually, the Board of Nursing) to make administrative rules with force of law in order to carry out the intent of the Act. The membership of the Board of Nursing is usually a majority of nurses (registered and licensed practical/vocational) plus members representing consumers, typically appointed by the governor of the state. The powers and duties of the Board of Nursing generally include regulating the practice of nursing; issuing initial and renewed licenses; setting standards and disciplining licensees who violate them; and approving basic nursing education programs.

Registered nurses are licensed to practice the full scope of professional nursing care, including assessment, analysis, planning, implementation, and evaluation. Aspects of care may be delegated to other RN's, to licensed practical nurses (LPN's) or to unlicensed personnel. LPN's are licensed to practice technical nursing functions under the supervision of RN's or physicians. In some states, some registered nurses have additional legal authority to practice as advanced practice registered nurses (APRN's). Their scope of practice extends to areas traditionally regarded as medical practice (diagnosing, prescribing, advanced physical assessments, etc.), and requires specialization as a nurse anesthetist, a nurse midwife, a nurse practitioner, or a clinical nurse specialist.

Unlicensed assistive personnel are employed to assist in delivery of aspects of nursing care. Currently, some types of assistive personnel are regulated in the United States, and discussion continues regarding the most effective regulatory approach for this type of worker.

NCLEX, the National Council Licensure Examination, is a national standardized examination that measures minimum competency for entry into nursing practice. It is oriented toward testing knowledge, skills and abilities needed in the first six months of practice, and toward assessing whether each candidate possesses at least minimum competence for safe and effective practice. Other requirements for initial licensure include completion of a state-approved basic nursing education program, submission of an application and fee, and other requirements that vary by state.

States require periodic renewal of licenses, which typically involves an application and fee, and sometimes require evidence of measures for continuing competence, such as continuing education units or hours of recent practice. Processes to re-enter the profession differ depending upon whether the absence was due to lapse of license or removal of license in disciplinary proceedings.

Nurses in the United States are able to obtain a license in another state through endorsement, which generally does not require retaking educational courses or examinations. Nurses from other countries are subject to credentials review and often to screening examinations. Foreign-educated nurses who meet all other qualifications and have passed the NCLEX may then be licensed.

Nursing regulation encompasses standards for nursing practice, directly or by reference. Standards include general professional, nursing, ethical, and direct care standards. Nurses are held to standards through their own individual and collective professional accountability to society and through the Nurse Practice Act and regulations with force of law.

The disciplinary process is a fundamental tool used by the Board of Nursing to carry out its responsibility to protect the public from unsafe nursing care. It provides for receipt of complaints, investigations, administrative hearings, and imposition of sanctions on the nurse's license.

The U.S. health care industry is currently under tremendous pressure for reforms to control costs. These pressures are influencing employers' choice of nursing care providers, ranging from advanced practice registered nurses to unlicensed nursing assistants. Policymakers and citizen groups are also pressing for increased access to health care and improvement in the quality of basic care. These pressures, coupled with the evolution of new settings and technologies for care delivery, present challenges to regulators of U.S. health professions to assure that their processes effectively protect the welfare of nursing care consumers without unnecessarily restricting the ability of providers, including nurses, to provide the maximum service of which they are capable.

Overview of Factors that have Shaped Licensure/Registration

Forms of Government

Political Structure

The United States Constitution provides a flexible framework for government as well as serving as a symbol of national unity and maintaining fundamental national ideals. It is the longest-lived national constitution in the world. Ratified in 1789, with the addition of a Bill of Rights (first ten amendments) in 1791 and 16 other amendments between 1798-1971, the U.S. Constitution remains the foundation of government in the United States.

Federal Government: The U.S. Constitution was drafted by representatives of the original states who were concerned that the new federal government should not become so powerful that it could usurp state sovereignty or trample on personal freedoms. In this federal form of government, state action must give way to federal law when a valid act of Congress fairly interpreted is in actual conflict with a law of a state. The powers not delegated to the federal government by the Constitution, nor prohibited by it to the states, are reserved to the states.

The U.S. Constitution provides for the separation of powers in three branches of government: the legislative branch, the executive branch and the judiciary. Each branch is independent, yet all branches are interdependent. This tripartite system assures a system of governmental checks and balances, and guards against the abuses of authority.

State Government: Each state of the United States has adopted a state constitution that also provides for the separation of governmental powers: the state legislative branch, the state executive branch and the state judiciary. Licensing laws governing individual health care providers have been traditionally enacted through state legislative action; in nursing, the law is typically called the Nurse Practice Act. State legislatures delegate many enforcement activities to state administrative agencies. In nursing, the Nurse Practice Act creates a state administrative agency, typically known as the Board of Nursing, to regulate nursing practice.

Territories and Commonwealth: Under the jurisdiction of the federal government of the United States are territories, comprising Pacific islands (American Samoa, Northern

Marianas, Guam) and Atlantic islands (Virgin Islands). Another Atlantic Island, Puerto Rico, is voluntarily associated with the United States as a commonwealth. The individual relationships between the territories, commonwealth and the United States vary, with each having a unique configuration of rights and responsibilities.

Roots of the Regulatory Approach

According to the U.S. Constitution, a major role of government in the United States is to provide for the health, safety and welfare of the public. All powers not specifically given to the federal government are reserved to the states, including "police power" to protect their citizens from harm.

State regulation of nursing is founded on the premise that consumers of nursing care can be assured of no harm only if regulations exist to require minimum qualifications of all who call themselves "nurses". The earliest discussions about issues of nursing self- regulation and legal regulation were considered in other countries, with New Zealand being the first country to enact a nursing licensing law in 1901. In the United States, Isabelle Hampton Robb is credited with founding the professional nursing association, which originally promoted nursing regulation. This organization was named the American Nurses Association (ANA) in 1911.

Between 1898 and 1902, state nurses associations formed, and these groups pressed for enactment of registration laws for nurses. In 1903, North Carolina became the first state to enact a registration law. By 1910, 20 states had enacted registration or licensure laws. By 1923, all 48 states, Hawaii, and the District of Columbia had enacted laws regulating nursing training. Prior to 1938, the laws did not require licensure for a person to hold oneself a nurse or practice nursing.

The early laws were known as Registration Acts. These laws provided title protection but did not include a definition of nursing or scope of practice statements. Early requirements for registration centered on the completion of an educational program meeting designated standards, successful completion of an examination, and evaluation of moral and character fitness appropriate for a nurse.

In 1938, New York became the first state to define the scope of nursing practice in the law and to adopt a compulsory law known as mandatory licensure. By the mid-1970's, all states had mandatory licensure laws defining a legal scope of practice.

Currently, in the United States, a license to practice nursing entitles one to use the title "Registered Nurse" (or "Licensed Practical Nurse"), the credentials following one's name (RN, LPN), and to perform the activities reserved to nursing in the legal scope of practice. Persons not possessing a license but who call themselves nurses or practice as nurses may be subject to administrative sanctions and/or civil penalties for violations.

Note: The equivalent of a licensed practical nurse (LPN) is a licensed vocational nurse (LVN) in California and Texas.

Summary:

- ***The foundation of nursing regulation is the Constitutional duty of government to protect the health, safety, and welfare of the public citizens.***
- ***The United States government is a federal structure, with the 50 states retaining any powers not specifically reserved to the federal government.***
- ***The regulation of nursing is carried out primarily through administrative agencies of the state, known as Boards of Nursing and comprised primarily of registered and licensed practical nurses.***

Geography

The United States is bounded on the north by Canada and on the south by Mexico. The country spans the continent east to west, and extends on the west and north to Hawaii and Alaska. Hawaii, Alaska, and the 48 continental states comprise the 50 United States. They vary greatly in physical size and features, from eastern lowlands and semitropics to western mountain ranges, midwestern plains, southwestern deserts and northwestern rainforests. Defined by square miles, the largest state is Alaska, the smallest Rhode Island. As previously mentioned, in addition to the 50 United States, several island territories: American Samoa, Northern Marianas, Guam and the Virgin Islands, along with the Commonwealth of Puerto Rico fall under the jurisdiction of the United States.

Demography

The current population of the United States is approximately 261 million. Defined by population, the largest state is California, the smallest Alaska. It is not possible to precisely state the number of U.S. nurses, since licensing is performed by each state and nurses may hold current licenses in more than one state. Estimates generally put the number of employed registered nurses at just under two million and the number of licensed practical or vocational nurses at approximately 600,000. This translates into ratios of approximately one RN for every 133 people.

There are currently estimated to be 60,000-100,000 advanced practice registered nurses in the United States, which are a subset of the two million RN's.

Ethnically, the United States is very diverse. Native Americans populated Alaska and many regions of the continent prior to the arrival of European explorers and settlers in the 17th century. Since then, people from every continent have migrated to the United States. The population is currently comprised of 1 percent Native American, 3 percent Asian, 10 percent Hispanic, 12 percent African American, and 74 percent non-Hispanic White.

While ethnic diversity in nursing does not currently mirror the population, many associations and educational institutions are working toward this goal. English is the predominant language of the country. Nursing is also a female-dominated profession: well over 90 percent of all nurses are women.

Health Care System

Unlike many other countries, the United States does not have a national health system in which the government is a direct provider of services. However, the government does provide funding for a variety of services. The funding primarily has supported programs of the Public Health Service, Medicare and Medicaid.

Established in 1798, the Public Health Service provides services such as routine immunizations, routine health screening, and programmatic services, such as care related to hypertension, diabetes, and sexually transmitted diseases. The Hospital Survey and Construction Act (Hill-Burton Act), passed in 1946, laid the framework for a coordinated system of hospitals and public health centers throughout the United States, with a focus on rural areas. Both federal and state government funding was used to finance the development and construction of the system.

In the 1960's, the government entered into health care financing in a major way with the passage of legislation establishing Medicare (federal payment for care for the elderly) and Medicaid (state payment for care for the poor and disabled, with standards set by the federal government). These financing programs, along with private financing provided by insurance companies, have been a powerful force in changing health care delivery in recent decades. For example, the length of time a patient stays in acute care facilities has decreased dramatically due to reimbursement formulas used by these government and private payers. The number of physicians in specialty practice has mushroomed due to the higher reimbursement rates available to them; simultaneously, critics claim that the quality of care provided to Medicaid patients has declined due to the low reimbursement rates for physicians under this program.

Accompanying the Medicare and Medicaid programs is a set of regulations for the licensing of health care facilities that receive federal funds, to be carried out by the states. These governmental rules, with which facilities must comply in order to continue operation, address issues such as training of personnel and required licensure levels. In the United States, facilities have long had the opportunity for voluntary accreditation through a private organization, the Joint Commission for the Accreditation of Health Care Organizations (JCAHO). Over time, JCAHO standards have changed their focus from prescribing processes and personnel to assessing health-care outcomes, regardless of process or personnel used. While most large acute-care facilities maintain JCAHO accreditation, the expense, which must be borne by the health care organization, has deterred many smaller hospitals and other types of health care organizations, such as long-term care facilities.

At the same time that the U.S. Congress has made efforts to reform the health care system, the health care industry itself has been actively restructuring, a process that has been dominated by hospital "downsizing". As a result of restructuring, fewer nursing positions are available in the acute care or hospital setting. Another element of restructuring is the increased merger and acquisition activity by hospitals and other health care facilities which follows a trend toward managed care.

In 1993-94, many proposals for health care reform were brought forward at the federal level, which included options ranging from "managed competition" to "single payer" systems. Major professional nursing organizations collaborated to develop Nursing's Agenda for Health Care Reform, which focused on controlling costs, promoting quality and access to care, and emphasizing wellness care and prevention (as opposed to the traditional medical model of treating illness). While no federal legislation has passed, many states have passed state-level reforms and are experimenting with various reformulated delivery and/or financing systems.

Essentially, managed care is a system in which fixed payment is made by a payer (insurance company) to providers on a "per patient per month" basis for the provision of a benefit package defined by the payer. For this "capitated" payment, all medically necessary care must be provided by the providers, even if it exceeds the payment amount. Theoretically, this is an incentive for providers to institute health promotion and disease prevention measures, to curb use of excessive tests and treatments, and generally to increase the efficiency and effectiveness of services. Practically, many believe cost reduction has become the only driving concern, at the expense of quality of care.

One effect upon nursing has been that health care providers with lesser levels of education and experience are frequently being substituted for nurses in acute care settings and long term care settings. Another effect is the opening up of opportunities in non-hospital settings, such as home-care, free-standing clinics and workplaces.

Workforce Issues

Beginning in 1944, U.S. nurses began to join labor unions for purposes of collectively bargaining terms and conditions of employment. Currently, about 10 percent of the RN workforce is unionized. In some states, the state professional nurses association is the collective bargaining unit. LPN's are more commonly represented by broad-based labor unions for workers in a variety of service industries or government.

Since the early 1950's, the demand for nursing services within the United States has been cyclical in nature. Factors affecting the demand for nursing services include an aging population, advances in technology, regulatory changes, and fluctuation in the number, age and general functional impairment of patients who require services. Demand for services has also been influenced by changes in the way systems of institutional and community-based nursing care is delivered, in nursing education, and in the organization of health care delivery itself.

As a female-dominated profession, nursing has faced limited upward mobility. This has occasionally resulted in disputes with the male-dominated medical profession over the expansion of nursing roles, particularly into independent provision of health care services. Also problematic is wage compression, the phenomenon of an acceptable pay rate for entry-level positions, in comparison with other professions, but with the potential for increased earnings that is only a small percentage of that enjoyed by other professions. Historically, nursing has generally been a profession with relatively easy access, mobility and flexibility in hours and schedules. But with recent restructuring activity, increasing market competition and emphasis on cost-containment, this flexibility has decreased.

Historical and Societal Issues and Trends

One factor that significantly affected the development of nursing regulation in the United States was that physicians sought and obtained licensure first, thus establishing by law and by custom an essentially limitless scope for physician practice. All other health professionals had to "carve out" a legal scope of practice, often after confrontation with physicians. These subsequent professions were licensed within prescribed practice boundaries.

The history of nursing in the United States is closely bound to the development of hospitals, most of which sponsored hospital-based training programs for nurses. Since hospital nursing services were usually performed by students, a majority of nurses provided private duty nursing services, either in the hospital or the home.

Early in the twentieth century, World War I created a shortage of registered nurses, and hospitals began to use "functional nursing", a task-oriented process whereby an individual nurse was assigned a specific care function, e.g., medication administration. Nursing assistants also performed some functions.

In the 1920's, the ANA focused on improved working conditions and increased economic security. During the Great Depression of the 1930's, U.S. nurses participated in many federal relief programs to assist in providing health care for the needy.

World War II stimulated the upward mobility of women and dramatically changed nursing in the United States. A shortage of registered nurses led to laws designed to ensure preparation of nurses in adequate numbers for military and civilian needs. The role of practical (vocational) nursing was developed to assist in providing nursing care on the home front. Nursing assistants also were used in large numbers. New medications, treatments, and technical advances were developed in response to the surgical and medical needs of the servicemen. Some procedures that initially had been carried out only by physicians (e.g., monitoring blood pressures with sphygmomanometers and giving intramuscular injections), began to be delegated to registered nurses. "Team nursing" was introduced, signaling a move away from functional nursing and task-oriented care to more holistic nursing care provided by RN-led teams of nurses and assistants.

With increasing population mobility in the 1950's, efforts were initiated to promote more consistency in state licensure laws. Nursing became the first profession to have a national licensing examination in 1951.

Associate Degree in Nursing (ADN) programs were developed in the 1950's as another method of addressing the shortage of registered nurses that dated back to the war. Instituted in community college settings, the two-year programs were to have replaced the three-year hospital school programs. Graduates of these programs were permitted to take the same licensure examination as diploma and baccalaureate graduates. The federal government's funding for the various types of nursing education programs has also been a factor in maintaining three distinct educational routes of preparation for RN's. This "three-tier" situation led to unclear regulatory policy and created conflict and turmoil within the profession. In

1965, the ANA adopted a resolution that set a 1985 goal for the requirement of a bachelor of science in nursing (BSN) for entry into professional nursing practice. While this objective has not yet been met, it was reaffirmed by the ANA in 1995.

In the 1970's, the concept of primary nursing was popularized. According to this concept, a registered nurse is responsible for 24-hour overall planning for a group of patients, as well as for the direct delivery of care to these patients while on duty. Emphasis on primary nursing in educational programs has resulted in a generation of nurses who have had less preparation in a team approach, delegation, supervision or management.

Summary:

- ***The diverse geography and demography of the United States presents unique challenges for assuring access to quality, competent health care services.***
- ***The U.S. health care system is currently under tremendous pressure for reforms to control costs, which influence employers' choice of nursing care providers.***
- ***The nursing profession and nursing regulation have been shaped by societal issues, such as women's and labor movements; by historical events, such as wars and changes in higher education; and by economic issues, such as shortages of nurses and government and private financing of health care.***

Current Status of Licensure/Registration

Locus of Authority for the Regulation of Nurses

Foundational Laws and Processes

In each of the 50 states, the District of Columbia and the territories, the practice of nursing is legally authorized by a state Nurse Practice Act. Five states, California, West Virginia, Texas, Louisiana and Georgia, have a second, separate law that authorizes the practice of the LPN/LVN. While multiple groups and individuals may influence the introduction and passage of practice act legislation, it is common for the state nurses association to maintain the most prominent role in legislative activity. As nursing practice and technology change, legislation to update the practice act may be introduced every few years.

In some states, other laws and/or rules govern all professional licensing boards or agencies. For example, the Administrative Procedures Act specifies how the Board of Nursing is to carry out its responsibility to develop administrative rules that operationalize the intent of the Nurse Practice Act. After a prescribed public hearing process, and approval by specified other state government entities, the rules have the force of law. Additionally, states have laws regulating institutions and employment settings, which may have bearing on the role of the nurse.

Other laws that influence nursing regulation in the United States include "freedom of information" laws and "sunset and sunshine" laws. Many states passed such laws in the 1970's and 1980's as a result of increasing societal demand for governmental accountability and responsiveness to consumers' concerns. Freedom of information laws require that most documents created or held by state governments and their administrative agencies, such as Boards of Nursing, be available to the public upon request under certain conditions. Sunset laws require boards to conduct self-assessments to justify their regulatory effectiveness or have their authorization withdrawn or "sunsetted." Sunshine laws require that most meetings held by state governments and agencies be open to the public, and that the time and place be announced beforehand in a specified manner. While certain categories of documents and meetings may be excepted from these provisions, generally, Boards of Nursing must conduct their business publicly (NCSBN, 1994c).

Nurse Practice Act Elements

Most Nurse Practice Acts include the following major elements (NCSBN, 1994b):

- Purpose of the legislation
- Definition of nursing practice
- Definition of each level of licensed nurse
- Creation of the Board of Nursing, including membership
- Powers and duties of the Board of Nursing: The Board's powers and duties typically include promulgating administrative rules consistent with the legislative intent (which have the force of law after approval), issuing licenses, disciplining those who do not conform to the law, and approving educational programs leading to initial licensure.
- Requirements for licensure, whether by examination or by endorsement from another jurisdiction with equivalent standards
- Duties of licensees
- Title protection

- Setting standards, regulating practice and determining whether an act is professional nursing
- Approval of basic nursing educational programs
- Violations
- Disciplinary process
- Exemptions to licensure requirements
- Authority to assess fees

All states except Mississippi and New York, and the territory of Puerto Rico, have a process for the approval of basic educational programs. Fees are variable from state to state, regarding both amount and whether the fees collected from licensees are dedicated to the Board for purposes of Nursing regulation. In many states, some portion of the fees must be remitted to the state for the funding of other unrelated activities of state government(NCSBN, 1994c).

Nature and Structure of the Regulatory Body

The Board of Nursing is typically comprised of a majority of nurses (registered and licensed practical) appointed by the governor of the state. The number may range from five to 25. Often, the nurse members are appointed to specific positions representing the various licensure levels (RN, LPN, perhaps APRN); the various educational levels (BSN, ADN, diploma); and practice settings (administrators, staff nurses). A few states have physician members on the board, or members of other professions regulated by the same board (such as psychiatric technicians). In nearly every state, the board also includes members of the general public, ranging from one to six. Appointments of public members became the practice in the 1970's, with proponents citing the rationales of public accountability and inclusion of the consumer perspective.

In some states, the Board of Nursing exists within an "umbrella" department that regulates a variety of professions and occupations. Such departments may take on functions such as issuing licenses or coordinating investigations. Even when Board operations fall under an umbrella structure, the Board of Nursing generally retains authority for the regulation of nursing practice.

Summary:

- ***Each state's Nurse Practice Act is the foundational law for the regulation of nursing practice in that state.***
- ***Nurse Practice Acts authorize an administrative agency of the state government, typically called the Board of Nursing, to make administrative rules with force of law to carry out the intent of the law.***
- ***The membership of the Board of Nursing is usually a majority of nurses plus members representing the public or consumers, typically appointed by the governor of the state.***
- ***The powers and duties of the Board of Nursing generally include issuing initial and renewed licenses, setting standards and disciplining licensees who violate them, and approving basic nursing education programs.***

Defined Levels: Advanced, Professional, Practical, Assistive

Registered Nurse

In the United States, all jurisdictions' Nurse Practice Acts protect the title of Registered Nurse and specify a scope of practice. The definitions vary somewhat from jurisdiction to jurisdiction, and scopes of practice vary slightly more. The following definition is fairly typical of those found in most jurisdictions' laws(NCSBN, 1994b):

The practice of nursing as a registered nurse means the practice of the full scope of nursing, which includes but is not limited to:

(a) assessing the health status of individuals and groups;

(b) establishing a nursing diagnosis;

(c) establishing goals to meet identified health care needs;

(d) planning a strategy of care;

(e) prescribing nursing interventions to implement the strategy of care;

(f) implementing the strategy of care;

(g) delegating nursing interventions to qualified others as provided in this Act;

(h) providing for the maintenance of safe and effective nursing care rendered directly or indirectly;

(i) evaluating responses to interventions;

(j) teaching the theory and practice of nursing;

(k) managing and supervising the practice of nursing; and,

(l) collaborating with other health care professionals in the management of health care.

After completion of secondary education, basic educational preparation as a registered nurse may be achieved by any one of the following routes:

- Completion of a four-year baccalaureate program with a major in nursing in a college or university;
- Completion of a two-year associate of science program with a major in nursing in a community (two-year) college;
- Completion of a three-year diploma program in nursing in a hospital-based program (NCSBN, 1994a).

Licensed Practical Nurse

The title of Licensed Practical Nurse (equivalent to Licensed Vocational Nurse in California and Texas) is also protected in all state Nurse Practice Acts. Scopes of practice are specified in all laws except those of Texas. Once again, definitions vary somewhat from jurisdiction to jurisdiction, and scopes of practice vary more. The following definition is fairly typical of those found in most jurisdictions' laws:

The practice of nursing as a licensed practical/vocational nurse means a directed scope of nursing practice that includes, but is not limited to:

(a) contributing to the assessment of the health status of individuals and groups;

(b) participating in the development and modification of the strategy of care;

(c) implementing the appropriate aspects of the strategy of care as defined by the Board;

(d) maintaining safe and effective nursing care rendered directly or indirectly;

(e) participating in the evaluation of responses to interventions; and,

(f) delegating nursing interventions to qualified others as provided in this Act.

The licensed practical/vocational nurse practices under the direction of the registered nurse, advanced practice registered nurse, licensed physician, or licensed dentist in the performance of activities delegated by that health care professional. LPN practice variations exist in the areas of intravenous therapy, ability to delegate nursing tasks, and extent of role in patient teaching, assessing and care planning (NCSBN, 1995a; 1995f).

Basic educational preparation for practice as an LPN typically consists of 12 to 18 months of nursing courses following secondary education. These may be offered in a community college or vocational education institution. Only a few programs still include preparation within a vocational secondary education program.

Advanced Practice Registered Nurses

Advanced Practice Registered Nursing in the United States generally includes: 1) advanced assessment of clients, including the synthesis, analysis and interpretation of the data, 2) providing expert guidance and client teaching, 3) managing clients' physical and psychosocial health-illness status, 4) utilizing research skills, 5) making independent decisions in solving complex client care problems, 6) performing acts of diagnosing and prescribing, and 7) working effectively with clients/families and other members of the health care team (NCSBN, 1994b).

In recent years, it has become increasingly common for U.S. jurisdictions to recognize and regulate advanced practice registered nurses. In 1993-94, both the ANA and the National Council of State Boards of Nursing (NCSNB) took positions which describe APRN's as RN's who:

- have qualifications as a Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Nurse Practitioner, or Clinical Nurse Specialist;
- have additional education beyond the basic RN education, ideally a master's degree in nursing or the relevant specialty area; and
- have advanced skills in physical assessment, nursing and medical diagnosis, and pharmacotherapeutics.

These positions assert that APRN's should be regulated solely by the Board of Nursing (not jointly with the Board of Medicine and/or Pharmacy), qualify for independent prescriptive authority, and practice independently of supervision by any other health care provider. At present, only a few jurisdictions implement the above position in all of its aspects. Data collected in 1994 indicates that the number of states regulating advanced practice are as follows:

Type of APRN	Number of States
Nurse Anesthetist	44
Nurse Midwife	45
Clinical Nurse Specialist	33
Nurse Practitioners	46

In 1993, legal authorization for advanced nursing practice had been granted to 14,749 Certified Registered Nurse Anesthetists, 2995 Certified Nurse Midwives, 3731 Clinical Nurse Specialists, and 32,224 Nurse Practitioners (NCSBN, 1995e; 1995f).

Because this is an emerging area of nursing regulation in the United States, the regulatory approach, and even the terminology used, varies from jurisdiction to jurisdiction. Some states issue APRN's an additional license, others add a designation to the RN license, some provide a letter of authorization or recognition, and still others issue a certificate to practice. There also is variation from state to state regarding the degree of reliance upon national specialty certification in granting APRN's this authority to practice. In most jurisdictions, regulation of APRN's is solely the responsibility of the board of nursing, while in others, this responsibility is shared with another entity, such as the Board of Medicine or the Board of Pharmacy (NCSBN, 1995e).

Variation also exists in the level of prescriptive authority, ranging from restricted to totally independent. Restrictions may consist of limitation to specific formularies/schedules/lists of drugs, or protocols/practice agreements arranged with collaborating physicians. Similarly, practice may be independent, or may require collaboration with a physician. Collaboration may be defined with varying degrees of stringency, ranging from a collegial relationship (e.g., a consultation and referral plan) to a specific written protocol/practice agreement, to direct supervision by the physician.

Educational programs for APRN's traditionally range from one year post-basic certificate programs to master's degree programs within universities (NCSBN, 1995e).

Unlicensed Assistive Personnel

In the United States, unregulated health care workers have been employed for many years to assist in the delivery of nursing care. Previously called nurse's aides or orderlies, these workers and their job titles have proliferated in recent years (e.g., medication aide, psychiatric technician, patient care technician). Currently, the major economic and social forces transforming the health care delivery system in the United States have created enormous pressures on health care managers to deliver lower-cost care, on nurses to delegate many tasks previously carried out only by licensed nurses, and on Boards of Nursing to determine what is safe for the patient/client.

Regulation of assistive personnel who work in long-term care (LTC) facilities receiving federal funds was initiated by the federal government in the 1980's, through passage of legislation that required regulation of LTC nurse's aides. The law also requires competency training, but not competency evaluation, for workers in home health care who perform nursing tasks; it has no provisions for nursing assistive personnel in acute care. A minimum of 75 hours of training in five specified areas (basic nursing skills, personal care skills, basic restorative services, mental health and social service needs, and residents' rights) and demonstration of competency on a written and a performance examination are required within the first four months of employment, or the facility may not continue to employ the individual as a nurse's aide. Additionally, the law establishes a registry of persons who allegedly abuse patients/residents or misappropriate their property. There is currently discussion among U.S. nursing regulators regarding whether all persons who assist in the provision of nursing care should be regulated, and if so, by whom and in what manner.

Educational preparation or competency training for the various types of unlicensed assistive personnel ranges from on-the-job training at the discretion of the employer to 150 hours of classroom and practical training (NCSBN, 1995f).

Summary:

- ***Registered nurses (RN's) are licensed to practice the full scope of professional nursing care, including assessment, analysis, planning, implementation, and evaluation. Aspects of care may be delegated to other RN's, to LPN's or to unlicensed personnel.***
- ***Licensed practical nurses (LPN's) are licensed to practice technical nursing functions under the supervision of RN's, physicians or dentists.***
- ***In some states, some registered nurses have additional legal authority to practice as advanced practice registered nurses (APRN's). Their scope of practice extends into areas traditionally regarded as medical practice (prescriptive authority, physical assessment, etc.) and involves specialization as a nurse anesthetist, a nurse midwife, a nurse practitioner, or a clinical nurse specialist.***
- ***Unlicensed assistive personnel are employed to assist in delivery of aspects of nursing care; currently some types are regulated in the United States. There is ongoing discussion regarding the most appropriate regulatory approach for this type of worker.***

Initial Requirements for Entry into Nursing Practice

Examination Requirement

Each jurisdiction's Nurse Practice Act and administrative rules determine the requirements for initial licensure for RN's and LPN/LVN's. All jurisdictions require passing a national, standardized examination, which tests whether the nurse candidate possesses the knowledge, skills, and abilities necessary to practice safely and effectively as an entry-level nurse. Entry-level has been defined in the United States as practice within the first six months following graduation from the basic nursing education program.

Nature and Structure of Examination

The current framework or test plan for the NCLEX-RN is two dimensional, the first dimension encompassing the nursing process and the second, client needs. The five phases of the nursing process, assessment, analysis, planning, implementation and evaluation, are represented by approximately equal numbers of questions on each examination. The categories of client needs are represented according to the results of the job analysis (see Validation of Content section below). Approximately 28 percent of questions reflect providing a safe, effective care environment; 45 percent reflect providing for patients' physiological integrity; 12 percent reflect providing for patients' psychosocial integrity; and 15 percent reflect providing health promotion and maintenance (NCSBN, 1995c).

For the NCLEX-PN, four phases of the nursing process are represented as follows: 30 percent data collection, 20 percent planning, 30 percent implementation, and 20 percent evaluation. The categories of client needs are represented according to the degree to which they were reported as subsuming activities of entry-level LPN's in the job analysis (see Validation of Content section below). Approximately 27 percent of questions reflect providing a safe, effective care environment; 45 percent reflect providing for patients' physiological integrity; 10 percent reflect providing for patients' psychosocial integrity; and 18 percent reflect providing health promotion and maintenance (NCSBN, 1996).

The examination is structured to be a unitary measure of the candidate's competence to practice nursing safely and effectively at entry level. Therefore, a single result is reported: pass or fail.

Conditions for Taking the Examination

A candidate must submit an application and fee to the Board of Nursing in the desired jurisdiction of licensure. Upon satisfactory review of the required evidence of completion of the nursing program and other licensure requirements, the Board authorizes the candidate's eligibility to take the NCLEX.

Orientation of the Examination

The examination is designed to reflect the knowledge, skills, and abilities required for practice. The intent is that licenses will be granted only to those competent to enter practice, i.e., those who possess at least the minimum competence required for safe and effective nursing practice.

The examination content is not based on the curricula of nursing education programs, and is not intended to be a summative test of success in mastering the content of the educational program. Similarly, the passing standard is not based on the relative performance of the group of candidates taking the examination, but on the best possible expert consensus regarding the minimum competence described above (NCSBN, 1995d).

Validation of Content

Content validity is demonstrated through a job analysis process, as is required by U.S. testing industry standards. Every three years, over 3000 nurses licensed within the past six months are surveyed regarding the criticality and frequency of over 200 nursing activities they may perform. Based on the responses to the surveys, and on the deliberations of an examination committee composed of representatives of Boards of Nursing, the framework or test plan for the examination is determined and percentages are assigned to each element of the framework. The framework and percentages are thus direct representations of the work that newly licensed nurses must actually do in their practice (NCSBN, 1995d).

Construction of Test

Questions for the NCLEX are written by nurses (educators and practitioners) across the country who write items in their area of expertise, fulfilling certain assigned areas of the test plan, under the guidance of professional test developers. Each test question is validated, or documented as accurately reflecting current practice, in at least two acceptable references.

After the items have been written, they are edited to assure that each question has one correct answer, three plausible distractors, and is free from several types of grammatical and test-writing errors. A second panel, composed of nurses in current clinical practice from around the country, reviews the questions to assure that they are reflective of current clinical practice, that there is one

clearly correct or best answer, and that it is appropriate for entry level.

Boards of Nursing may also review the questions and file comments on questions that they find to be beyond entry-level or outside of the legal scope of practice in the respective jurisdiction. Such items are removed from the pools of test questions if a comment is substantiated.

Finally, each test question must undergo field testing in actual examinations prior to being used as a basis for scoring to gather statistical results. These results are used as a basis for accepting or rejecting the question for continued use (NCSBN, 1995d).

Scoring and Basis for Determining Passing

The examination is administered by a process known as computerized adaptive testing. Each candidate's examination is assembled interactively as the individual is tested. As the candidate answers each question, the computer scores it and calculates a "competence estimate" based on all earlier answers. The test questions, which are stored in a large item bank and classified by test plan area and level of difficulty, are then scanned. The question determined to measure most precisely the candidate's knowledge in the appropriate test plan area is selected and presented on the computer screen. This process is repeated for each question, creating an examination tailored to the individual's knowledge and skills while fulfilling all NCLEX test plan requirements. The examination continues in this way until enough information has been accumulated to make a reliable pass or fail decision. Each candidate's examination includes at least 75 items, and may include as many as 265 items depending on how much information is needed to make a reliable decision.

The passing standard is based on the minimum level of content mastery required for safe practice as identified by surveys of nurse employers and educators, trend data, and the judgment of a panel of experts participating in a structured decision process. Passing standard studies occur on three-year cycles, and are timed to coincide with the introduction of a revised test plan. Although jurisdictions are free to set their own passing standard, all have used the nationally-recommended standard since about 1980 (NCSBN, 1995d).

Process for Eliminating Bias

Potential item bias in the NCLEX is detected through two processes: statistical analysis and expert judgment. Statistical analysis is routinely performed on all test questions. The results of this analysis are given to a bias sensitivity review panel which evaluates the text and the statistical analysis of questions for indications of bias that might cause members of a particular gender or ethnic group to do less well on the question, unrelated to their nursing ability. When such questions are identified, they are removed from the question pools (NCSBN, 1995d).

Process for Assuring Security and Fairness

The content of every examination conforms to the test plan as outlined above. Every candidate's performance is compared to the same passing standard. Testing conditions are standardized (identical directions and operating procedures), since tests are administered in 200 computer centers operated under the same conditions across all jurisdictions. The computerized adaptive testing process has the advantage of permitting year-round testing without compromising fairness and accuracy for all candidates (NCSBN, 1995d).

Retake Process

Candidates who fail the NCLEX may repeat it at intervals no shorter than 91 days. Some jurisdictions limit the number of retakes or the time period over which a candidate may make repeated attempts to pass the examination. Some jurisdictions also mandate that the unsuccessful candidate must repeat some or all of the educational program in order to become eligible to retake the NCLEX. In the remaining jurisdictions, candidates may continue to attempt to pass the examination without limitation (NCSBN, 1995d).

Other Requirements

In addition to passage of the national examination, all jurisdictions require graduation from a school of nursing approved by the jurisdiction. Other requirements that some jurisdictions may uphold include good moral character, no prior felony convictions, and English language proficiency.

In order to qualify for initial licensure, the applicant must submit an application to the Board of Nursing (or state-government department fulfilling this function) with the appropriate fee. In some jurisdictions, graduates of approved educational programs may work under supervision as graduate nurses on a temporary license during the time between educational program completion and receiving the results of their examination (NCSBN, 1994c).

Summary:

- ***NCLEX, the National Council Licensure Examination, is a national standardized examination for entry into nursing practice. It is oriented toward testing knowledge needed in the first six months of practice, and toward measurement of minimum competence.***
- ***NCLEX content covers the nursing process and client needs such as physiological integrity and health promotion and maintenance.***
- ***Fairness and integrity are assured through secure and standardized administration of computerized adaptive tests with field-tested, multiple-choice questions.***
- ***Other requirements for initial licensure include completion of a state-approved basic nursing education program, submission of an application and fee, and various other requirements.***

Ongoing Licensure

Renewal/Continuance

All jurisdictions require periodic renewal of the license to practice nursing. The period for which the initial license is valid varies from one to three years. In every jurisdiction, renewal requires submission of an application and a fee. In some jurisdictions, requirements for evidence of continuing competence also must be met (NCSBN, 1994c).

Re-Entry

If a nursing license lapses for any reason, the individual may have his or her license reinstated by complying with the requirements of the jurisdiction, which will include fees, and may include fulfillment of continuing education requirements and/or refresher courses.

If a nursing license has been suspended or revoked for cause in disciplinary proceedings, re-entry requirements are specifically tailored by the Board to the individual's violation, and may include courses, treatment programs, supervision, mentoring, consultation, or formal evaluations (NCSBN, 1994c).

Continuing Competence

In general, nursing regulators in the United States operate on the assumption that in the absence of substantiated complaints, licensed nurses continue to be competent to practice safely and effectively over the years. Twenty-seven jurisdictions require that licensees obtain nursing continuing education in order to qualify for renewal of an active license. Twenty-four jurisdictions require that the licensee has practiced at least a specified number of hours within the period of licensure just ending. No other mechanisms, such as competency testing or performance review, are currently in use in any jurisdiction (NCSBN, 1994c).

Summary:

- ***Jurisdictions require periodic renewal of licenses, which involves submission of an application and fee.***
- ***Some jurisdictions have requirements designed to assure continuing competence, such as continuing education or recent practice.***
- ***Processes to re-enter the profession differ depending upon whether the absence was due to lapse of license or removal of license in disciplinary proceedings.***

Mobility

Within Country

When a nurse licensed in one U.S. jurisdiction wishes to become licensed in another U.S. jurisdiction, the nurse must make application for endorsement. Endorsement is a process whereby the desired jurisdiction of licensure evaluates the nurse's current licensure status and the conditions under which the nurse initially qualified for licensure, by requesting verification of licensure and other pertinent data from the jurisdiction of original licensure. If these verifications reveal that the licensure requirements of the jurisdiction of application were substantially met or exceeded, and the license is unencumbered, the jurisdiction of application will issue a license by endorsement. In most cases, the nurse will not have to retake the licensure examination or take any additional courses; however the nurse may be required to document recent nursing practice (NCSBN, 1994c).

From Other Countries

When the candidate has been educated outside of the United States, the candidate's educational preparation is compared to the jurisdiction's requirements. Some jurisdictions employ staff to perform this review.

Many jurisdictions utilize the credentials review process provided by the Commission on Graduates of Foreign Nursing Schools. For the 41 jurisdictions that require foreign-educated candidates to pass the CGFNS Qualifying Examination prior to becoming eligible to take the NCLEX-RN, the credentials review is an integral part of the qualifying process. If the credentials review confirms that the individual's education is that of a "first-level nurse" (International Council of Nurses historic definition), the individual must then pass the CGFNS qualifying examinations in nursing knowledge and English proficiency.

Regardless of whether or not the candidate is required to take the CGFNS examination, every candidate is required to take the NCLEX-RN. Since there is no similar qualifying examination for prospective LPN's, foreign-educated candidates whose education and credentials are satisfactory to the board are authorized to take the NCLEX-PN.

In addition to fulfilling jurisdictional licensure requirements as described above, all nurses coming into the United States also have to fulfill legal requirements regarding immigration rules and work permits (NCSBN, 1994c).

Summary:

- ***Nurses in the United States are able to cross state boundaries and obtain a license in another state through endorsement, which generally does not require retaking of educational courses or examinations.***
- ***Nurses from other countries are subject to credentials review and often to screening examinations; foreign-educated nurses who meet all other qualifications and have passed the NCLEX may then be licensed.***

Regulatory Standards

Definition and Focus on Regulation

As professional nursing evolved in the United States, the term "standards" developed multiple meanings and perspectives. Presently, "standards" may be used to describe standards for clinical practice or clinical performance, frequently called clinical protocols. For purposes of this discussion, standards of practice are those intended to provide general guidelines for nursing practice.

Sources: Self-Regulation, Regulatory Body, Government

Historically, standards were considered to represent the ideal for professional performance and behavior, but were not prescribed by law or rule of any official regulatory entity. This standard of personal accountability for professional practice remains an expectation for nurses today. In addition, collective accountability of all nurses for the ethical and effective practice of nursing is fostered by professional nurses' associations at the state and national levels. The ANA develops standards of practice and also publishes the ANA *Social Policy Statement*, which describes the collective accountability of nurses to society. Standards of practice for a number of specialties also have been developed.

As courts and external evaluators deliberated issues related to privacy, confidentiality, protection of property, provision of care regardless of diagnosis, non-discrimination and respect of client rights, gradually Boards of Nursing were encouraged to develop standards that could be legally enforced. Currently, sixty Boards indicate that they have authority to establish practice standards by administrative rule or policy.

Types of Standards

The purpose of standards is to establish acceptable levels of safe nursing practice and to serve as a guide for the Board of Nursing when evaluating the practice of nurses. Standards are subject to ongoing evaluation and revision to meet the changing needs of society and the development of the profession.

General Professional Standards

General professional standards define the legal boundaries for practice as a member of a profession. For nursing, these standards include that the nurse will accept responsibility for individual nursing actions, competence and behavior; will function as a member of the health care team; will respect client rights and property; and will protect confidential information unless obligated by law to disclose the information.

Forty-five U.S. jurisdictions include in their standards a requirement for mandatory reporting by which a nurse is obligated to report violations of the Nurse Practice Act or administrative rules to the Board of Nursing (NCSBN, 1994c).

Nursing Standards

Generally-maintained standards for professional (RN) nursing practice include the following:

1. Conduct and document nursing assessments of the health status of individuals, groups and communities;
2. Establish and document nursing diagnoses that serve as the basis for the strategy of care;
3. Develop a strategy of care based on assessment and nursing diagnosis;
4. Implement the strategy of care;
5. Evaluate the responses of individuals, groups, or communities to nursing interventions; and
6. Delegate to another only those nursing measures which that person is prepared or qualified to perform, supervise the delegatees, and retain professional accountability for delegated nursing care.

Ethical Standards

The most commonly held ethical standards of practice involve acting consistently in the best interest of the patients for whom one has assumed responsibility. A nurse is bound to maintain responsibility for the care of a patient when that care is within his or her capability to provide, and may not abrogate that responsibility for reasons of personal preference or convenience. The ANA has developed a code of ethics, that is universally acknowledged and utilized as the foundation of virtually every ethical provision incorporated in statute or regulation.

Direct Nursing Care Standards

Recently, the Agency for Health Care Policy and Research (AHCPR) published research-based protocols for clinical management of specific conditions. Standards of practice (or standards of care) may also refer to the criterion or standard of performance to which a certain activity or intervention is held. Direct nursing care standards, such as those developed by professional associations, may be referenced in Board of Nursing rules and called upon in any legal proceedings regarding whether a nurse observed the standards of care. Some Boards of Nursing directly set standards of nursing care, such as through the issuance of formal statements or advisories on specific aspects of care.

Summary:

- ***Nursing regulation encompasses standards for nursing practice, directly or indirectly.***
- ***Standards include general professional, nursing, ethical, and direct care standards.***
- ***Nurses are held to standards through their own individual and collective professional accountability to society and through the Nurse Practice Act with its force of law.***

Provisions for Sanction of Licensure/Registration

The primary responsibility of Boards of Nursing is the protection of the public health, safety and welfare through the regulation of nursing practice. The discipline process, which includes investigating, disciplining for violations, and monitoring disciplined nurses, is crucial to the fulfillment of the Board's responsibility.

Each jurisdiction's law and rules provide the framework for the discipline process. The options available at different points in the discipline process may be identified by the Board's attorney, while determination of disciplinary action remains the prerogative of the Board.

Sources of Complaints

Complaints may be filed by the general public, patients and their families, employers of nurses, other professionals and other nurses. Complainants usually must identify themselves and state the specific allegation of violation. Boards also may receive notice of possible violations via other routes, such as notification by insurance companies of malpractice payments made on behalf of nurses.

Most jurisdictions are required to maintain and annually report to the governor counts of complaints received, the disposition of complaints, and the length of time required to resolve cases.

Grounds for Discipline

Grounds for discipline in the states typically include failure to meet qualifications; fraud or deceit in procurement of a license; inability to practice safely because of illness, use of alcohol/drugs, physical or mental condition; unprofessional conduct; conduct creating a risk of harm; disciplinary action in another jurisdiction; unethical conduct; engaging in sexual conduct with a patient; diverting drugs or controlled substances; and aiding an unlicensed person to engage in the unlawful practice of nursing (NCSBN, 1994c).

How Complaints are Addressed

Complaint receipt and review: Complaints are received and reviewed by the Board of Nursing. If the complaint does not relate to a violation for which the Board of Nursing is authorized to take disciplinary action, or if the complaint involves an individual or situation for which the Board does not have jurisdiction, the complaint would be dismissed or referred to the appropriate agency. If the alleged facts were true and would constitute grounds for disciplinary action, an investigation is conducted. In many states, a priority ranking is assigned to the case based upon the seriousness of the allegations.

Investigation: Investigatory activities include requesting additional documents from a complainant, phone calls to clarify information, interviews with the licensee and other witnesses, and inspection of the site of the alleged incident(s).

Evaluation of Complaint and Investigatory Findings: Based on the investigation, the board may determine probable cause, that is, that there is sufficient basis to proceed with the filing of charges. If the investigation does not support a finding of probable cause, the complaint is dismissed.

Emergency Action: A Board may initiate emergency action at any point in the disciplinary process should imminent danger to the public be identified. Because of due process considerations, standards and procedures for use of emergency actions are strict. Due process is the legal steps and measures to which a person is entitled to protect himself and his interests. While the type of action will be based on the specifics of the case, an example of an emergency action is immediate suspension of the license.

Administrative Proceedings: The goal is to determine 1) the facts, 2) whether the facts constitute grounds for discipline, and 3) the consequent sanction. The formal administrative hearing process begins with focus on the allegations in the document of charges and proceeds to a determination, based upon the evidence presented, of whether the state has proven the charges. Both the licensee and the Board are usually represented by legal counsel, and witnesses are called. Hearings are public in some states.

Since formal hearings are both unpleasant and expensive for the licensee, many states also use an alternate method. When the licensee is willing to admit that certain charges are true, the Board and licensee may arrive at a negotiated settlement that imposes a sanction congruent with the facts admitted or stipulated.

Sanctions

The sanctions or remedies used by a Board of Nursing are defined in the Nurse Practice Act. Some examples of common sanctions include:

1. To deny or refuse to issue, reinstate or renew a license;
2. To place a license on probation or condition the retention of the license upon compliance with ordered terms and conditions (examples of terms or conditions would be required education, monitoring, or reports);
3. To limit or restrict the nurse's scope of practice (examples would include prohibiting the nurse from administering controlled substances, working only under supervision of another RN, or working only in certain settings);
4. To suspend a license, thereby removing the nurse from nursing practice for either a definite or an indefinite period of time;
5. To revoke or annul a license, thereby terminating the nurse's license;
6. To reprimand or censure a nurse's behavior;
7. To otherwise discipline (examples might be fines, restitution or community service).

Sanctions by the Board of Nursing present no bar to further criminal prosecution; additionally, civil penalties may be authorized. Violation of the Nurse Practice Act is often considered a misdemeanor for the first offense and a felony for the second. Final disciplinary action taken by a Board of Nursing is a matter of public record (NCSBN, 1994b; 1994c).

Cross-Jurisdiction Sharing of Information

Once a Board of Nursing takes disciplinary action, most jurisdictions report the action to the National Council Disciplinary Data Bank, which is a clearinghouse of disciplinary information regarding over 33,000 cases. Information is accessible to all other Boards of Nursing and to other agencies that credential nurses.

A federal law passed in 1986 established a National Practitioner Data Bank (NPDB), which is intended to be a repository of disciplinary actions as well as malpractice payments made concerning health care professionals. Currently, reporting to the bank is mandatory only for physician and dentist data, and for malpractice payments made on behalf of all health care professionals including nurses. There is intent to extend required reporting of Nursing Board actions to the NPDB in the future. The most frequent users of the data are employers, who are required to check the bank prior to employment and at regular intervals thereafter.

Summary:

- ***The disciplinary process is a fundamental tool used by the Board of Nursing to carry out its responsibility to protect the public from unsafe nursing care.***
- ***The disciplinary process provides for receipt of complaints, investigations, administrative hearings, and imposition of sanctions.***

Emerging Regulatory Issues and Trends

Major issues expected to have the greatest impact on nursing regulation in the United States during the next five years include:

Reform of the Health Care Delivery System

- Restructuring and reform influenced by market-driven competition, cost containment, and business and public dissatisfaction with the current system.
- Emphasis on health care reform emanating from legislative activity, as well as demands for reform arising from the business and public sectors.

- Newly developing health care delivery structures, such as managed care and primary care, which press for changes in existing regulatory structures.
- Diminished acceptance of unique scopes of professional practice, with emphasis on multi-skilled providers.
- Changing care-delivery focus away from acute care to home and community-based nursing care.
- Increased use of registered nurses in non-traditional roles and settings.
- Redefinition of nursing roles by employers including overlapping of other health care providers with traditional nursing roles; increased use of and expansion of the role and activities of unlicensed personnel; expansion of the role and activities of unlicensed assistive personnel; and their use in settings with little or no direct nursing supervision.
- Pressure on nurses to accept unsafe assignments, such as mandatory delegation of patient care to unlicensed personnel unprepared to exercise nursing judgment crucial to safety and effectiveness.
- Regarding advanced practice nursing, the legitimization and increasing use of such nurses; their increased use in non-traditional roles and settings; independent prescriptive authority; standardization of educational requirements; and regulation solely by Boards of Nursing.
- The use of telecommunications for delivering health care services at a distance from the patient, and resulting issues of patient protection, accountability, and confidentiality.

Pressures for Change in Regulatory Systems

- Challenges to the state-based regulatory system including the authority of Boards of Nursing versus that of other nursing regulatory agencies, and exploration of other approaches, including licensure of or by institutions rather than individuals.
- Emphasis on outcomes and quality, resulting in closer scrutiny of professional practice.
- Demands for more substantial evidence of the continued competency of licensees.
- Emphasis on standardization of requirements to facilitate mobility and promote consumer access to health care.
- Increased Board of Nursing workload relative to disciplinary complaints, investigations, and monitoring of disciplined nurses.
- Increased federal intrusion into the regulation of professionals.

Societal Issues

- Emergence of more issues with ethical implications, including patient self-determination, informed consent, abortion, and euthanasia.
- Growth of the consumer rights movement, with increasing emphasis on openness and accountability of government, and participation in decision-making.
- The importance of sensitivity to cultural, ethnic, and racial diversity in health care delivery as well as in educational programs preparing professionals.

Nursing Issues

- Continuing controversy over whether the baccalaureate degree should be required for entry into professional nursing practice.
- The role of LPN's, including specialization, extended or additional technical or procedural activities, and length of educational program.

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Similarities and Differences in Licensure/Registration of Nurses and Standards of Practice in Canada, Mexico and the United States

Part Three has described the various modes by which nurses throughout North America are licensed, and the standards of practice to which these nurses must adhere to retain their credentials.

In this section of Similarities and Differences, characteristics such as licensure, regulation and monitoring of practice are summarized according to each country's procedures.

Characteristics	Canada	Mexico	United States
Origin of Nursing Licensure/Registration	In 1910, the first provincial law for registration of nurses is passed (Nova Scotia).	In 1945, Nursing and Obstetrics is included in the General Law on Professions.	In 1903, the first state Nurse Practice Act is passed (North Carolina).
Foundation Laws	Canadian Constitution Canada Health Act Provincial Laws	Political Constitution of the United States of Mexico Federal Laws General Laws Federal Labor Law	United States Constitution State Laws
Nursing Laws	Provincial Nursing Acts	General Law on Professions (federal)	State Nurse Practice Acts
Regulatory Bodies	Provincial Nursing Acts	General Law on Professions (federal)	State Nurse Practice Acts
Defined Levels **– Advanced**	Under discussion	None	Advanced practice RN (nurse practitioner, clinical nurse specialist, anesthetist, midwife)
– First Level	Registered Nurse	Licenciatura	Registered Nurse
– Second Level	Licensed Practical Nurse or Nursing Assistant (or variation)	Técnico	Practical Nurse or Licensed Vocational Nurse
Unlicensed	Health care aides, etc. unregulated	Auxiliary - unregulated	Nurse aides, etc. - some regulation
Requirements for Initial Licensure/Registration/ Cédula	• Graduation from approved nursing school. • French or English proficiency and other requirements according to the province. • Pay fee. • Pass national examination. • Proof of legal name. • Many jurisdictions also have requirements for good character, no criminal record relevant to nursing, and references. Two provinces have citizenship/ residency/ work permit requirements.	• Examination at end of academic program. • No criminal record. • Graduation from officially recognized school. • Completion of community service. • Professional degree registration. • Proof of legal name (with certificate). • Pay fees.	• Graduation from approved nursing school. • English proficiency and/or other requirements according to the state. • Pay fees. • Pass national examination (NCLEX).

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Characteristics	Canada	Mexico	United States
Licensing Examination	National examination (CNATS) based on job analysis of entry-level nursing practice.	Choice between written thesis and defense or 1000 question written examination.	National examination (NCLEX) based on job analysis of entry-level nursing practice.
Conditions to Take the Examination	• Complete education. • Show proof of recent practice. • Pay fee. • Examination authorization.	• Complete education. • Complete community service. • Examination authorization.	• Complete education. • Pay fee. • Examination eligibility.
Basis for Determining a Passing Grade	350 CNATS examination passing score prior to 1995 (RN's) or 1996 (PN's). Subsequently is criterion referenced (competency based) standard, scored only by pass/fail.	• Oral and practical examination established by the faculty. • Written examination graded on score of 1 to 10, with minimum passing grade of 7.	Criterion-referenced, based on competency standard for minimum safe practice.
Procedure for Ethnic, Gender, Disability or Racial Bias	External test of fairness. Group reviews questions for ethnic, racial, gender, disability bias. Accomodation offered to candidates with disabilities.	Care is based on ethical principle of no distinction by race, creed or gender.	Statistical and judgmental analysis performed regularly; accomodations offered for candidates with disabilities.
Procedure for Ensuring Security	Detailed standardized procedures by national testing service.	Responsibility of the educational institutions.	Detailed national uniform procedures and testing facilities.
Procedure for Repeating Examination	RN exam offered four times a year, PN exam three times. Each jurisdiction sets own retake rules.	Three opportunities are granted to take the examination.	No limit. Must wait at least 90 days between retakes.
License Renewal/Continuity	Periodic renewal (usually annual) with fee required, or continuous with annual fee required, depending on jurisdiction. Many jurisdictions require recent practice or study.	Continuous; does not expire.	Periodic renewal varies from one to three years; requires fee. Some states require continuing education or recent practice.
Re-entry (after lapse or discipline)	Same prerequisites as initial entry, except examination.	Same prerequisites as initial entry.	Same prerequisites as initial entry, except examination. May be required to retake exam.
Continuing Competence	Many jurisdictions require evidence of recent practice or education. Other continuing competence mechanisms are in development in some jurisdications.	Education and continuous upgrading on the job is required under Federal Labor Law and General Health Law.	Some states require continuing education; some require evidence of recent practice.
Entry of Foreign-educated Nurses	Must meet all initial entry requirements, including evidence of equivalent education, English or French fluency, and national examination.	• Must meet all initial requirements, plus provide evidence of equivalent education. • Revalidation of education. • Payment of title registration. • Spanish language proficiency.	• Must meet all initial requirements, plus provide evidence of equivalent education. • In majority of states, obtain a certificate from the Commission on Graduates of Foreign Nursing Schools (which requires demonstration of nursing knowledge and English proficiency).

Characteristics	Canada	Mexico	United States
Regulatory Standards Sources	• Nursing Acts. • Misconduct regulations and others approved by regulatory body and promulgated by government. • Standards of practice, ethics, conduct established by regulatory body. • Federal Criminal Code and jurisdiction provincial offense statutes.	• Constitution, General Law on Professions, and General Health Law. • Federal Labor Law. • Health institution standards developed by nurses. • Penal Code. • The ICN code (ethics).	• Nurse Practice Acts. • Professional associations. • Criminal and civil code.
General Professional Standards	May not: • practice without a certificate/license. • practice beyond own level of knowledge/competence or legal authority. • abuse or abandon patients. • fail to report violations by other nurses. • breach patient confidentiality. • breach nursing standards of clinical practice, conduct, ethics, etc. established by regulatory body.	May not: • practice without a license. • practice as a foreigner without authorization. • prescribe without legal authority. • abuse or abandon patients. • fail to report violations by other nurses. • breach patient confidentiality.	May not: • practice without a license. • practice as a foreigner without authorization. • prescribe without legal authority. • abuse or abandon patients. • fail to report violations by other nurses. • breach patient confidentiality. • document care inaccurately or incompletely. • fail to collaborate with other providers.
Provisions for Sanctions Source of Complaints	Employers, consumers, coworkers, general public.	Patients, supervisors, colleagues, authorities of health institutions.	Employers, consumers, coworkers (mandatory in some states), general public.
Grounds	Breach of nursing standards or practice, such as unprofessional/unethical conduct, incompetence, impairment, etc.	Violation of penal code or institutional policy.	Violations of Nurse Practice Act, such as unprofessional conduct, abandonment, impairment, etc.
Complaint Management	By regulatory body in accordance with investigation/adjudicative provisions in Nursing Act, and other applicable jurisdiction laws governing administrative, quasi-judicial tribunals.	According to penal code or Institutional discipline and dispute resolution process.	State administrative law and Board policies govern investigation, filing charges and adjudication.
Sanctions	Most commonly: revocation, suspension, probation, reprimand, fine.	Sanctions determined by the health institution and/or penal code.	Most commonly: revocation, suspension, probation, reprimand, fine.
Cross-jurisdiction Sharing of Information	National Discipline Database (RN related) scheduled for 1996 implementation.	Through procedures for access to any court case.	Through National Council Disciplinary Data Bank.

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Opportunities & Recommendations

Licensure/Registration of Nurses and Standards of Practice in Canada, Mexico and the United States

The major similarities and differences in the regulatory/licensure structures and standards affecting nursing in the three countries have been identified in the foregoing section. The significant areas of similarity bode well for the success of efforts to facilitate mobility. In addition, there is enormous similarity in the nature of the changes and challenges facing health care generally, and nursing in particular, in all three countries. No difference exists in the common commitment to safe quality patient care. The dialogue and relationships that have developed during the Trilateral project provide a valuable opportunity for the profession in the three countries to examine how sharing information and working together will help them address these challenges in their own jurisdictions.

Nevertheless, some major differences exist in the structure and philosophy upon which the systems for licensing/registration of nurses in the three countries are based. It is not the purpose or intention of this project to suggest that all of these differences should be reduced or eliminated merely for the sake of standardization. This section identifies those major differences that, directly or indirectly may be barriers to mobility, and suggests some opportunities and areas for future discussions.

Seven areas in which major differences have been identified are as follows:

- the purpose and philosophy of nursing regulation;
- the checks and balances among the roles and responsibilities of the nursing profession, government, educators and consumers in the regulatory model;
- standards of practice;
- legislated titles;
- entry to practice criteria;
- monitoring of ongoing competence; and
- public access to complaints.

The differences are articulated below, along with opportunities for mutual learning and possible action.

Purpose of Nursing Regulation

Major Difference	Canada	Mexico	United States
What is the purpose of nursing regulation?	Professionally To provide safe and effective care in the public interest. Structurally Protection of the public articulated in regulatory law.	Professionally To provide safe and effective care in the public interest. Structurally Not articulated in regulatory law.	Professionally To provide safe and effective care in the public interest. Structurally Protection of the public articulated in regulatory law.

Philosophy of Nursing Regulation

Major Difference	Canada	Mexico	United States
What is the role of nursing in the regulation of professional nurses?	Lead Role. Nursing is delegated regulatory authority by the province, i.e., self-regulation. Majority of members of the regulatory body are selected by the profession. In most cases, this body is the professional nursing association; in one case, it is a separate, non-governmental body.	Supplementary. Direct government regulation, without significant involvement of the profession.	Hybrid regulation by state governmental agencies made up primarily of nurses, generally appointed by state governor.

Opportunities

Congruency in expected nursing competencies and professional behavior would promote mobility. This will most readily occur when nursing is intimately involved in establishing and enforcing entry to practice and continuing competence requirements. This points to an opportunity for the three countries to work together to:

1. **Clearly articulate that the purpose of establishing entry standards and other regulatory criteria for nursing is to provide public protection and safe, quality nursing care.**

2. **Clearly communicate and promote understanding among governments of the need to link the nursing profession with the regulation of the profession.**

Checks and Balances on Roles and Responsibilities

Major Difference	Canada	Mexico	United States
Government Role	Delegates regulatory authority to non-government body. Ultimately accountable for regulatory body carrying out functions according to legislation and mandate.	Ministry of Education directly responsible for establishing general curriculum standards for all educational programs.	Delegates regulatory authority to state administrative agency. Ultimately accountable for regulatory agency carrying out functions according to legislation and mandate.
Role of Regulatory Body	Establishes standards of practice and entry-to-practice criteria, registers/licenses nurses, monitors ongoing competence, and disciplines. In some jurisdictions, the regulatory body approves education standards and facilities.	No separate nursing regulatory body.	Establishes entry-to-practice criteria, registers/licenses, monitors ongoing competence and disciplines. Usually establishes education standards and approves education programs.
Role of Nursing Education Accreditation and Approval	Accredits education programs through private national system. Reviews and monitors at other levels.	Grants first stage license approval. No central accrediting system.	Requires mandatory approval by regulatory body; voluntary accreditation by private national system.
Role of Professional Associations	In most cases, has both regulatory and general professional functions. No collective bargaining functions.	No direct role in regulation.	No direct role in regulation but establishes standards of practice, and may provide collective bargaining.
Role of the Consumer	Some provinces include consumer members in regulatory body. Consumers have access through the disciplinary process (filing of complaints and knowledge of disciplinary actions).	No direct role in regulation.	Most Boards include consumer members. Consumers have access through the disciplinary process (filing of complaints and knowledge of disciplinary actions).

Opportunities

By providing an appropriate balance between the role of government, the regulatory body and professional associations, nursing education ensures that necessary nursing participation occurs, while avoiding potential conflicts of interest. This need for balance offers opportunities to:

3. **Evaluate the checks and balances to ascertain whether nursing knowledge is being provided where it is needed to assure the safety of nursing care to all consumers.**

4. **Mutually consult and assess various configurations. For example, should the determination of licensing/registration eligibility be seperate from the nursing education system? Should professional associations be separate from the regulatory system? Where separateness occurs, how can fragmentation and confusion be avoided?**

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Standards of Practice

Major Difference	Canada	Mexico	United States
Who establishes the standards of the profession?	The provincial regulatory body often using the national professional association model as resource.	No set of state or federal standards of practice articulated.	The state professional association, often using the national professional association model as resource.
Who determines entry-to-practice requirements?	Provincial regulatory body.	Individual education facility and Ministry of Education and Health.	State regulatory body.
Who defines competence?	Provincial regulatory body.	Education facility at graduation, and employer at entry and for continuing competence.	State regulatory body.

Opportunities

A range of commonality in standards of nursing practice is reasonable in terms of promoting safe, quality nursing care throughout North America, and is essential to the mobility of nurses. Yet, standards of practice need to take into account the unique health care delivery systems and expectations of the individual countries; expecting detailed uniformity of standards from country to country may be unrealistic. Opportunities exist to:

5. **Develop mutual understanding of the similarities and differences among the regulatory standards of practice of the countries and their relationship to ensuring safe practice in the context of the country's health care system.**

6. **Work together to develop clear definitions of minimum and ongoing competence as well as strategies to measure competence.**

7. **Establish common criteria to evaluate existing safeguards designed to ensure that standards of competence and education are congruent with safe, quality practice.**

Legislated Titles

Major Difference	Canada	Mexico	United States
Titles			
Advanced Practice	No specific regulation or protected title at current time.	No specific regulation or protected title at current time.	• APRN (Advanced Practice Registered Nurse) • CRNA=anesthetist • CNM=midwife • NP=practitioner • CNS=clinical specialist
First Level	RN (Registered Nurse) RPN (Registered Psychiatric Nurse-provinces)	Lic. (Licenciada en Enfermera) (English=Licensed Nurse with a Bachelor's in Nursing)	RN (Registered Nurse)
Second Level	Practical Nurse (different terms used in different jurisdictions—registered nursing assistant, licensed practical nurse, registered practical nurse, and certified nursing assistants).	Enf. (Enfermera Tecnico) (English=Technical Nurse) * In Mexico, technical nurse is treated as first level nurse.	Licensed Practical Nurse, Licensed Vocational Nurse
Unlicensed	Unregulated Health Care Provider (known by variety of names, including health care aide, homecare worker, unit assistant, personal support worker). Not regulated by nursing, and no legislated title protection.	Auxiliar (English=Auxiliary Nurse/Nurses Aide)	Unlicensed Assistive Personnel (a few protected titles such as CNA, certified nursing assistant; many job titles including orderlies, nurse aide, medication aide, psychiatric technician, patient care technician.) Frequently regulated by department of health or similar agency.

Opportunities

Differences in titling point to opportunities to:

8. **Develop a common understanding of titles and terminology, and exchange information for accurate comparison.**

9. **Share understanding gained from the United States experience with establishment of legal authority for an advanced level of nursing practice.**

10. **Jointly analyze appropriate uses of unlicensed workers and the skills and knowledge needed by nurses of varying titles and levels to work effectively together for the provision of safe, quality patient care.**

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Entry-to-Practice Criteria

Major Difference	Canada	Mexico	United States
Years of Education			
Advanced Practice	Not applicable	Not applicable	Professional nurse with specialized experience and further education, usually at master's degree level.
First Level	12 or 13 years primary and secondary school + 2 or 3 year post-secondary diploma program in community college or hospital, or 4 year nursing baccalaureate university program.	12 years primary and secondary school + 4 year university program + completion of year of community service.	12 or 13 years primary and secondary school + 2 year associate of science in nursing program in community college, or 3 year hospital diploma program, or 4 year baccalaureate in nursing program.
Second Level	Generally 12 years primary and secondary school + 12-18 month post-secondary nursing program (or in small number of cases, co-operative secondary school program).	9 years primary and secondary school + 3 year nursing program + completion of year of community service.	Generally, 12 years primary and secondary school + 12-18 month post-secondary program in a community college or vocational school (or in small number of cases, co-operative secondary school program).
Unlicensed	Varies from few weeks employer training (with no minimum primary/ secondary education) to 12 years primary/ secondary education plus up to 12 months community college.	Varies	Varies, evolving from on-the-job training to government or employer mandated training of 40-150 hours.
Qualifying Examination	National examination	Comprehensive examination set by individual educational facility.	National examination
Nature of Qualifying Examination	Uniform, standardized exam oriented to practice and knowledge; psychometrically validated.	Individual facility examination, set by Master Teacher selected by faculty and oriented to academic curriculum.	Uniform, standardized exam oriented to practice and knowledge; psychometrically validated.
Community Service in Field of Study	Not applicable	One year (similar to internship)	Not applicable

Opportunities

These major differences in the entry-to-practice criteria provide opportunities to:

11. **Identify information and resources that could assist in the development of a uniform, standardized entry-to-practice examination in Mexico, oriented to minimum practice expectations.**

12. **Jointly analyze the perceived barriers to mobility regarding the diverse routes of preparation for entry to practice or the diverse standards of practice, along with specified reasons they are believed to represent barriers.**

Monitoring of Ongoing Competence

Major Difference	Canada	Mexico	United States
License Renewal	Generally renewed annually.	None	Generally required every one to three years.
Means of Monitoring Competence	Through complaints received by regulatory body. Varies, but most provinces require specified number of hours of practice for license renewal. At least two provinces (British Columbia, Ontario) are implementing program to actively require demonstration of ongoing competence and learning.	Through complaints received by employers through direct supervision of nursing personnel.	Through complaints received by regulatory body. Some jurisdictions require number of hours of practice for license renewal; some require hours of continuing

Opportunities

All three countries face similar changes in health care delivery systems and health care knowledge base, along with increasing demands and expectations required for nurses to maintain competence. Similarly, all three countries are facing the challenge of how to monitor and measure ongoing competence effectively. These challenges offer opportunities:

13. **For the three countries to pool information and resources to address this issue in order to most effectively facilitate public protection and professional development of nurses.**

14. **For Mexico to consider license renewal as a vehicle to move toward assurance of ongoing competence.**

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Public Access to Complaints

Major Difference	Canada	Mexico	United States
Who is Responsible?	Regulatory body	Employer, Government	Regulatory body
Process	Explicit administrative rules governed by principles of due process.	No explicit process articulated outside the penal code.	Explicit administrative rules governed by principles of due process.
Requirements to Respond to Public Complaint	Explicit statutory responsibility to respond to formal complaint from member of public, and to make disciplinary action information available.	No explicit response articulated other than public court proceedings.	Explicit statutory responsibility to respond to formal complaint from member of public, and to make disciplinary action information available.

Opportunities

All three countries explicitly or implicitly concur that the fundamental purpose of nursing regulation is safety of patient care and public protection. A formal discipline process is a core element of any system for achieving such protection. Because one of the most effective means of enforcing commonality in nursing standards and professional expectations is having a formal discipline process and public access to the regulatory process, opportunities exist to:

15. **Develop information resources on the core elements of nursing disciplinary processes and the effectiveness of various approaches.**

16. **Ensure that each country has an articulated process to investigate/assess complaints and impose discipline.**

17. **Centralize and share information on discipline outcomes both within and across jurisdictions, to ensure that the public is not endangered by incompetent or unethical practitioners who may be taking advantage of mobility opportunities.**

Final Recommendations

The final recommendations include an overall goal accompanied by major opportunities as synthesized from those on the preceding pages.

Overall goal: **To develop mutual understanding of the similarities and differences among the countries' regulatory standards of practice, including ongoing competence, and their relationship to ensuring safe practice in the context of each country's health care system.**

Major Opportunities

The three countries should:

1. Work together to articulate and promote government understanding that the purpose of regulation of nursing is to protect the health, safety and welfare of the public, and that the nursing profession and nursing regulation must be linked in order to achieve this purpose.

2. Mutually consult on various configurations for achieving appropriate checks and balances among the roles of government, nursing regulatory and educational bodies and professional nursing associations to assure provision of safe and effective nursing services for consumers.

3. Work together to develop mutual ongoing confidence that each country's standards for practice and competency ensure the delivery of safe, quality nursing services to consumers in all settings.

4. Jointly analyze the continuum of healthcare providers, from unlicensed providers to advanced practice nurses, to identify the skills and knowledge each needs to provide safe, quality patient care.

5. Mutually evaluate methods of assuring ongoing competency and urge Mexico to consider:

   a. license renewal as a specific vehicle to move toward such evaluation;

   b. the establishment of an articulated disciplinary process within control of an established nursing regulatory body which allows the public to register complaints about nursing practice; affords justice and due process for both the nurse and the complainant; and provides an appropriate mechanism for discipline, sanctioning and monitoring.

Part Four

Nursing Specialty Certification in Canada, Mexico and the United States

Part Four assesses and compares nursing specialty certification in the three countries. Certification is a process whereby an individual is granted recognition for having met predetermined criteria for a nursing specialty that have been set by non-governmental professional associations or certifying organizations. Usually voluntary, formalized, and national in scope, nursing specialty certification attests to an individual's competence in the field of nursing for which certification is sought.

Following individual chapters on specialty certification within each country, a summary of key similarities and differences is presented. While some aspects of the process are similar among the three countries, significant differences are identified in a number of important areas, including the purposes of certification, the examination development process, levels of certification, and the process for recertification. Because certification demonstrates a degree of excellence above and beyond basic nursing practice, an awareness of such differences in standards is important. Following this section are recommendations for further information sharing and collaborative action on specialty certification among Canada, Mexico and the United States.

Nursing Specialty Certification in Canada

Gail Tomblin Murphy, RN, BN, MN
Canadian Nurses Association

Executive Summary

This document provides an overview of nursing certification in Canada. In Canada, certification in nursing specialties has developed as a voluntary professional credentialing mechanism in the last 15 years. However, many Canadian nurses also hold nursing specialty certification from bodies outside Canada, particularly in the United States.

Since 1992, the Canadian Nurses Association (CNA) has operated the only nursing specialty certification program that exists in Canada. The CNA offers certification in seven nursing specialties and has certified over 2,500 nurses. The program is expected to grow to 11 specialties, with 19,000 certified nurses, by the year 2000.

One of the key elements of the CNA Certification Program is the belief that specialty groups define the specialty using a given set of criteria. The defining dimensions describe the uniqueness of the specialty. The process encourages the refinement of nursing roles regarding nursing phenomena and the articulation of nursing knowledge, and assists in documenting the nature of various specialties, thereby contributing to the development of nursing as a science.

The ongoing development of the CNA Certification Program calls for flexibility in adapting to future changes. Education and practice requirements for certification and advanced nursing practice are among areas to be addressed as the program continues to evolve. As specialization in nursing develops, the requirements for certification will change to reflect these developments.

Historical Factors

The Origins of Specialty Certification in Canada

The CNA Certification Program was initiated by membership request in June 1980 through a biennial resolution that directed CNA "to study the feasibility of developing examinations for certification in major nursing specialties". An initial investigation confirmed the growing interest of nurses in the development of certification and revealed that several nurses were seeking certification in the United States. An ad hoc committee on credentialing was established that developed a policy on credentialing in nursing as well as recommended that CNA promote the development of a certification program in nursing specialties. That document was adopted by the Board of Directors in 1982 (CNA, 1982).

Between 1982 and 1986, a series of three ad hoc committees on certification, in consultation with national nursing groups, studied the policy issues underlying a cer-

tification program. As a result of the work of these committees, a certification program was designed and approved in October 1986.

In 1982, occupational health nurses in Canada established the Canadian Council for Occupational Health Nurses Incorporated (CCOHN, Inc.) for the purpose of developing and administering a certification program in occupational health nursing. In 1984, certification in occupational health nursing was offered for the first time. CCOHN, Inc. and the American Board for Occupational Health Nurses Incorporated (ABOHN, Inc.) agreed to provide certification by reciprocity to nurses who wished to be certified in both the United States and Canada. Under this agreement, U.S. and Canadian certified nurses were exempted from writing the other program's examination in order to achieve certification in the other country.

In 1992, the CCOHN, Inc. Certification Program was integrated into the CNA Certification Program. The CNA is currently examining reciprocity between Canadian and U.S. certification programs which would include the ABOHN, Inc. program.

In 1991, the CNA certified its first group of nurses in neuroscience nursing. As of 1995, certification was offered in seven specialty areas, including: neuroscience, occupational health, nephrology, emergency, critical care, psychiatric/mental health and perioperative nursing.

The Definition and Purposes of the CNA Certification Program

CNA defines certification as a voluntary and periodic process (recertification) by which an organized professional body confirms that a registered nurse has demonstrated competence in a nursing specialty by having met predetermined standards of that specialty. Recertification is interpreted as renewal of certification.

The purpose of certification is threefold:

- To promote excellence in nursing care for the people of Canada through the establishment of national standards of practice in nursing specialty areas;
- To provide an opportunity for practitioners to confirm their competence in a specialty; and
- To identify, through a recognized credential, those nurses meeting the national standards of their specialty.

CNA's Certification Process

The CNA Certification Program is divided into three phases: designation of a specialty, development of a certification examination, and certification and recertification of individuals.

Phase I: Designation of a Specialty For Certification

A fundamental element of the CNA Certification Program is the belief that specialty groups define the specialty using a given set of criteria. CNA encourages the specialty groups to define their area of nursing in terms of recurrent phenomena rather than using the more traditional medical model.

Any group of nurses may apply to CNA to designate a specific area of nursing as a specialty for the purpose of certification by submitting a proposal. To date, proposals received by CNA for designating specialty areas have been submitted by recognized specialty groups representing nursing at the national level. The proposal should answer the question "How is this specific area of nursing unique and different from general nursing practice?"

The criteria for designating a specialty for certification are:

The specialty

- has established standards;
- addresses recurrent phenomena in practice;
- has developed a role description for its practitioners;
- is supported by a body of nursing literature, education and research;
- has identified the number and distribution of registered nurses in the specialty; and
- has the human resources to support the certification process.

The proposal is reviewed by the Special Committee on Certification. This committee makes recommendations to CNA's Board of Directors. The Board of Directors makes a final decision on designation for certification. Once a specialty is designated for certification, the CNA determines when examination development for the specialty will begin based on current CNA priorities and financial resources.

Phase II: Development of a Certification Examination

The Testing Division of the CNA is responsible for the development and administration of the nursing specialty certification examinations. The activities associated with the development of a certification examination are based on professionally accepted testing principles and procedures.

Throughout the test development process, nurses from the specialty, who are experts in the content area, work together with the CNA staff, who provide the professional expertise required to produce a high-quality examination. A committee structure has been adopted to accomplish the various functions associated with the development of the examination (See Appendix A).

The certification examinations are criterion-referenced. The standards of practice, recurrent phenomena, role description, and body of knowledge of the nursing specialty are further refined into competencies required of nurses who work in the specialty and serve as the basis upon which the certification examination is developed. The competencies are then validated by means of a survey of a representative sample of the nurse population working in the specialty. These competencies, along with some additional criteria (e.g., client age, health care setting, etc.) become the components of the examination blueprint.

Nurses in the specialty develop the competencies and examination blueprint, write and review test questions, and set the standard (pass mark).

Phase III: Certification and Recertification

The eligibility requirements to become certified in all designated specialties include:

- current registration/licensure in Canada as a registered nurse;
- appropriate education and experience in the specialty;
- a letter of reference from a supervisor or a consultant in the specialty; and
- successful completion of the certification examination (See Appendix B).

The certification credential is valid for five years. To become recertified in a specialty, the nurse must meet the eligibility criteria for certification, with one exception. The nurse has the choice of rewriting a certification examination or meeting the requirement of 100 hours of continuing education in the specialty (See Appendix C). Certified nurses earn the privilege to use the certification credential of their specialty area (See Appendix D).

The Administrative Elements

The Special Committee on Certification and the Committee on Testing are concerned with the general aspects of the Certification Program (See Appendix E). In addition, each specialty has an Examination Committee that oversees the content of the examination and acts as a review and standard setting body. The chairs of these committees also sit on the Committee on Testing.

Current Status of Specialty Certification

As of 1995, CNA offered certification in seven specialties: neuroscience, nephrology, occupational health, emergency, critical care, psychiatric/mental health, and perioperative nursing. The neuroscience examination was first offered in 1991. The nephrology nursing and occupational health nursing examinations were offered beginning in 1993. Emergency nursing certification was offered for the first time in 1994. Critical care, psychiatric/mental health and perioperative nursing were offered for the first time in 1995. To date, 2,677 nurses have been certified through the Certification Program. Table 1 shows the number of nurses that were certified at the end of 1995 by nursing specialty, and projected totals for 1996.

Table 1 Number of Certified Nurses by Nursing Specialty

Nursing Specialty	Critical Care	Emergency	Psychiatric/ Mental Health	Nephrology	Neuroscience	Occupational Health	Perioperative	Total
Total at end of 1995	145	461	242	260	140	934	495	2677
Expected total for 1996	375	717	542	363	189	1145	906	4237

Future Developments

In June 1991, the CNA Board of Directors appointed an ad hoc committee with the mandate to address key policy issues affecting the viability and growth of the CNA Certification Program, and to formulate a plan for its development to the year 2000. The committee's recommendations and plan have provided direction for the facilitation and acceleration of the expansion of the Program (CNA, 1992).

It is anticipated that by the year 2000, CNA will offer certification in 11 specialties, and that 19,000 nurses will be certified. The program will expand to include specialty areas, such as oncology (by 1997), pediatrics, gerontology, maternal/newborn, and community health nursing.

Program Assumptions

The committee also identified the following assumptions under which the program would operate:

- Certification promotes high standards of nursing care.
- Certification contributes to the public good.
- Nurses working in specialty areas are interested in becoming certified.
- The demand for certification warrants the continuation of a national program.
- Consistency of certification standards is best assured if the program is administered by a single organization.
- A pool of nurses could potentially apply for certification in the different specialty areas that would support the maintenance and development of the Certification Program.

Emerging Issues and Trends

The committee also identified the following areas of research and issues to be considered with regard to specialization/certification and the future development of the program:

1. **Classification System of Nursing Specialties for the Purpose of Certification**

   The establishment of a framework to define, label and categorize nursing specialties would facilitate the development of the Certification Program. A classification system would allow the categorization of several specialty areas within major classes of nursing that share common knowledge, skills and abilities. A classification system also could allow the organization of nursing specialties as parent specialties and subspecialties.

2. **Eligibility Requirements**

   - Experience in the nursing specialty

   Empirical evidence is needed to support the assumption that two years of practice in a specialty (or all specialties) is sufficient for a nurse to acquire the knowledge, abilities and skills required to practice at the level of competence expected of a certified nurse.

   - Education

   By the year 2000, the baccalaureate will be required for entry into practice. There will be a need to review this requirement in relation to the Certification Program.

3. **Advanced Level of Certification**

   CNA will be studying the feasibility of providing for an advanced level of certification (e.g., Master's prepared nurses).

4. **Offering Certification in Specialty Areas with Small Numbers of Nurses**

   Since 1993, in order to ensure that the Certification Program becomes financially self-supporting, CNA has favoured the development of certification in areas with larger numbers of nurses (i.e., a minimum of 10,000 nurses). CNA is committed to offering certification in specialties with smaller numbers of nurses and is studying different strategies in order to expand its program to include these specialty areas.

5. **Reciprocal Arrangements with Other Certification Programs**

   CNA is studying the desirability and feasibility of entering into reciprocal arrangements (e.g., waiving examination requirement to certified nurses) with other certification programs.

References

Canadian Nurses Association. (1982). Credentialing in nursing: Policy statement and background paper. Ottawa: Author.

Canadian Nurses Association. (1992). Plan of action for the orderly development of the CNA Certification Program to the year 2000. Ottawa: Author.

Canadian Nurses Association. (1994). CNA's Certification Program: An information booklet. Ottawa: Author.

Appendix A

Test Development Cycle

The activities associated with the steps in the test development cycle for certification examinations are described below and presented in a diagram on the following page. Certification examinations are offered in both official languages, English and French.

Committee on Testing

The Committee on Testing (COT) recommends to the CNA Board of Directors policies relating to examinations, and approves procedural guidelines relating to testing. The committee reports regularly to the Board of Directors on its activities.

Examination Committee

The Certification Examination Committee monitors the examination development process by approving the examination at the following steps of development: blueprint, item review and appraisal, the total examination, and setting the passing mark.

Competency Development

As the foundation for a criterion-referenced examination, the competencies (e.g., knowledge, skills, abilities, attitudes, and judgement) required for competence in the specialty area are identified by a special committee with regional representation. The competencies undergo an extensive study in which they are validated in terms of relevant criteria (i.e., applicability, importance, frequency). The competencies are reviewed periodically to confirm their validity over time.

Blueprint Development/Revision

A blueprint outlining the content to be tested in the examination is developed by the Certification Examination Committee. The blueprint includes the competencies, that is, the content domain that forms the basis for test development. It also specifies variables that provide structure for the examination, as well as guidelines and weightings for test development.

This step, like competency development, is not included in each cycle of the test development process. A blueprint is developed for the first examination and is revised periodically, at appropriate intervals (approximately every 5 years).

Item-Writing

Examination items are developed by the Examination Committee and by additional groups of item writers, when required. These groups write examination items to measure the specific competencies and to fulfill the guidelines identified in the examination blueprint.

Item Appraisal and Review

Items are revised by nurses in the specialty area across the regions to ensure that the items measure content consistent with the current standards of practice. In addition, representatives from minority groups (e.g., aboriginals, visible minorities, individuals with disabilities) review the items to ensure that examinees who belong to such groups are not disadvantaged by examination content and that no stereotypes are inadvertently reflected in the items.

Compilation of the Certification Examination

The examination is compiled from items in the test bank to meet the specifications of the blueprint.

Approval of Examination

Final approval of the examination is given by the Certification Examination Committee.

Setting the Passing Mark

The Examination Committee determines the standard (i.e., passing mark) by using an appropriate standard-setting procedure. This process is done prior to examination administration.

Item Analysis

All items are analyzed statistically to determine their suitability for inclusion in the examination.

Item Revision

Sometimes items have content problems or do not meet certain criteria at checkpoints in the development cycle. For example, they may not meet statistical criteria established for item analysis, or they may not meet the approval of certain groups (i.e., item review and appraisal groups, Examination Committee). Items requiring revision before they are included in an examination are revised by the Examination Committee or by experienced item writers, if required.

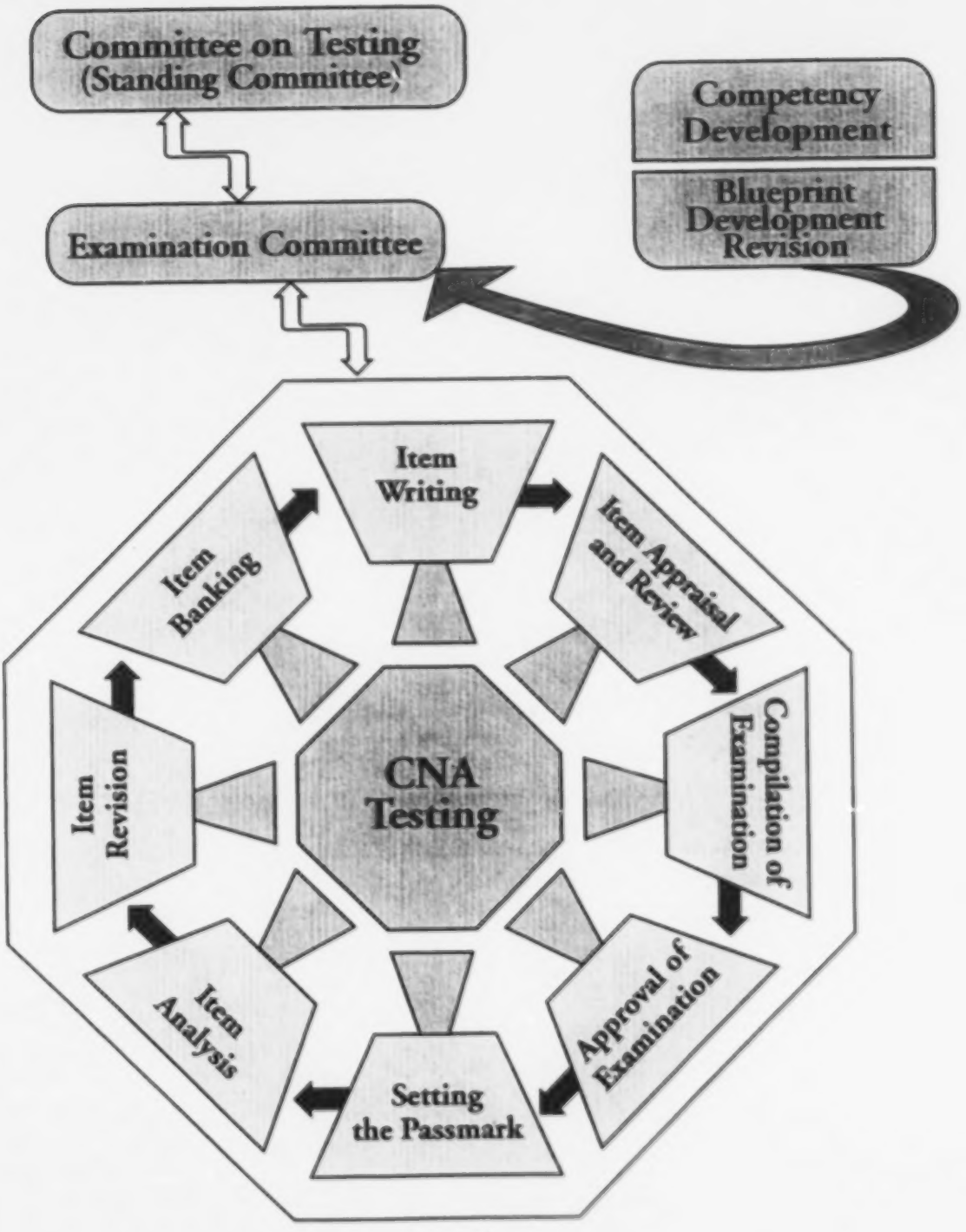
Item Banking

Test items are stored in an item bank and are drawn upon for constructing future examinations.

Source:
Canadian Nurses Association Testing Division. (1995). Test development cycle for certification examinations. Ottawa: Author.

THE TEST DEVELOPMENT CYCLE

for Certification Exams



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Appendix B

Eligibility Requirements for Certification

To achieve CNA Certification applicants must:

1. hold current registration/licensure as a Registered Nurse in Canada;
2. have appropriate experience and education in the specialty (see box below);
3. submit a letter of reference from their supervisor or a consultant in the specialty;
4. submit the application materials, including all necessary documents and fees; and
5. pass the certification examination.

Experience/Education Requirements for All Specialties except Occupational Health Nursing

- 2 years full-time experience* (or part-time equivalent) in the specialty during the 4 years immediately prior to applying;

OR

- 1 year of full-time experience* (or part-time equivalent in the specialty during the 3 years immediately prior to applying, *plus* satisfactory completion of a post-basic program in the specialty area, formally recognized by either the professional association or educational institutions within the province/territory.

*Full-time experience is defined by the candidate's provincial/territorial registering body.

Experience/Education Requirements for Occupational Health Nursing Applicants

- 4 years of full-time experience* or 6 years of part-time experience in the specialty (minimum 600 hours per year) in the 7 years immediately prior to applying;

OR

- satisfactory completion of a nursing degree or post-basic program in Occupational Health Nursing *plus* 3 years of full-time experience* or 6 years of part-time experience in the specialty (minimum 600 hours per year) in the 6 years immediately prior to applying;

PLUS

- 75 continuing education contact hours in the specialty or related field within the 5 years immediately prior to applying.

*Full-time experience is defined by the candidate's provincial/territorial registering body.

Eligibility Requirements for Recertification

To recertify in the CNA Certification Program the applicant must:

1. hold current registration/licensure as a Registered Nurse in Canada;
2. have had 2 years of full-time* experience (or part-time equivalent) in the specialty during the 5-year certification term;
3. submit a letter of reference from his/her supervisor or a consultant in the specialty; and
4. submit all necessary application materials, documents and fee.

Recertifying through Continuing Education

If applicants choose to recertify through continuing education (C.E.), they must meet the following guidelines:

- A minimum of 100 hours of C.E. activities;
- A maximum of 25 hours can be obtained through professional participation;
- Each C.E. activity must relate to their specialty area;
- Each C.E. activity must be a minimum of 30 minutes;
- If applicants repeat C.E. activities during the 5-year certification term, they count only as one activity (e.g., CPR).

Source: Canadian Nurses Association. (1995). Candidate Application Information Booklet. Ottawa: Author.

Appendix C

Recertification Through Continuing Education

To recertify in a specialty through continuing education, the applicant must complete 100 hours of continuing education related to the specialty within the last five years.

A minimum of 75 hours must be formal education (See description below).

A maximum of 25 hours can be professional participation (See description below).

Applicants must keep all supporting documentation on file until they receive notice that they are recertified in their specialty. CNA randomly audits applications. If an application is audited, the applicant will be asked to submit proof of the continuing education hours completed.

Formal Education

All continuing education must relate to the specialty area.

Examples of formal education activities include:

- Credit courses shown to have relevancy to the specialty;
- Non-credit courses/opportunities formally recognized by either the professional association or educational institutions within that province/territory;
- Educational opportunities taken as workshops, seminars, correspondence courses or teleconferences.

Each documented educational opportunity must have a minimum length of 30 minutes.

Professional Participation

Professional participation is recognized by CNA to include both group and individual activities.

Group Activities include involvement with the specialty interest group; participation on a board of directors, in committee work and/or with health policy groups. The applicant will be required to show how participation in group activities is related to the specialty area. The applicant cannot claim travel or preparation time necessary to participate in any group activities.

Individual Activities are related to the specialty and could include: lecturing, or participating in research, teaching and/or preparing publications. Hours submitted to CNA for individual activities can include preparation time for lectures/presentations. For each 30 minutes of a lecture or presentation, one hour of preparation time can be claimed.

Recurring Educational Opportunities

Some educational opportunities may be repeated within the five-year period. Such educational opportunity will be approved only once. For example, presentation of a particular paper at a meeting would be allowed only once in a five-year period, unless the applicant can show significant changes to warrant duplication of hours being granted. If the continuing education activity is repeated at a higher level, both levels can be accepted (e.g., different levels of CPR above the basic, which would be required for the specialty).

Approval of Continuing Education

CNA will formally approve, at the time of application for recertification, the continuing education hours submitted. Candidates will be contacted by CNA should clarification of a continuing education activity be necessary.

Verification documentation could include: CNA's Verification of Continuing Education form completed and signed, receipts and brochures of workshops attended, committee agendas and/or minutes, outlines of lectures or copies of programs, sponsors' acknowledgements (proof that material was given).

Source: Canadian Nurses Associations. (1995). Candidate Application Information Booklet. Ottawa: Author.

Appendix D

Canadian Nurses Association Certification Program

Registered Certification Initials for Designated Specialty Areas

Designated Specialty Areas	Registered English Credential	Registered French Credential
Critical Care Nursing	CNCC(C) Certified Nurse in Critical Care (C)anada	CSI(C) Certifiée en soins intensifs (C)anada
Emergency Nursing	ENC(C) Emergency Nurse Certified (C)anada	CSU(C) Certifiée en soins d'urgence (C)anada
Nephrology Nursing	CNeph(C) Certified in Nephrology (C)anada	CNeph(C) Certifiée en néphrologie (C)anada
Neuroscience Nursing	CNN(C) Certified in Neuroscience Nursing (C)anada	CSN(C) Certifiée en sciences neurologiques (C)anada
Occupational Health Nursing	COHN(C) Certified in Occupational Health Nursing (C)anada	CST(C) Certifiée en santé du travail (C)anada
Perioperative Nursing	CPN(C) Certified in Perioperative Nursing (C)anada	CSP(C) Certifiée en soins périopératoires (C)anada
Psychiatric/Mental Health Nursing	CPMHN(C) Certified in Psychiatric and Mental Health Nursing (C)anada	CSPSM(C) Certifiée en soins psychiatriques et de santé mentale C)anada

Appendix E

Administrative Elements

1. Committee Structure

The Special Committee on Certification and the Committee on Testing are concerned with the general aspect of the certification program. In addition, each specialty has an Examination Committee that oversees the content of the examination, and acts as a review and standard setting body. The chair of this committee also sits on the Committee on Testing.

2. The Certification Administration System

The administration system includes such things as notification to the candidates of examination times and examination sites, entering the nominal roll into the Testing Division's computer, printing of examinations, quality control of printing, packaging, shipping and receiving. In addition, there is the preparation of all examination materials; e.g., test information brochures for candidates, invigilator (proctor) manuals, appeal procedure guidelines, answer sheet production, scanning procedures, test administration, site selection and test security measures. Also in the administration system is the support for the scoring program, the creation of machine-readable examination keys, the running of the optical mark reader, data collection, data verification procedures, reporting of results to Certification Services, generation of statistical reports, results verification and quality control.

3. Certification Services

The CNA Certification Services coordinate the delivery of services to certification candidates and certified nurses. The Certification Services coordinate the certification application review process as well as plan, organize, implement, monitor and evaluate the records management of certification candidates' and certified nurses' files. In addition, the Certification Services oversee all communication with applicants; act as a resource in the resolution of irregular or complex problems; and coordinate communication concerning instructions to candidates, procedures for registration and the transmittal of candidate rolls, identification cards and results. The Certification Services are responsible for the design and production of candidate information materials and the preparation of advertisements and promotional material related to the certification examination writings. The Certification Services issue all certification certificates and oversee the recertification process. The Certification Services also provide assistance to the committees concerned with certification. This keeps the Certification Services apprised of the specialties coming on-line and the committees informed on current developments within the Certification Program.

4. Funding

To date, CNA has funded the development of the CNA certification infrastructure and the development of examinations in Neuroscience Nursing, Nephrology Nursing, Occupational Health Nursing and Emergency Nursing. Funding was secured from the Federal Government for the development of the Critical Care Nursing, Psychiatric/Mental Health Nursing and Perioperative Nursing certification examinations.

Source: Canadian Nurses Association. (1992). Plan of action for the orderly development of the CNA Certification Program in the year 2000. Ottawa: Author.

Nursing Specialty Certification in Mexico

Lic. Josefina Reyes González
Colegio Nacional de Enfermeras, A.C.

Lic. Juana Jiménez Sánchez
Colegio Nacional de Enfermeras, A.C.

Executive Summary

This chapter presents a brief historical background on the evolution of post-technical and specialty courses for nurses in Mexico. Both types of courses have been shaped by the needs of health institutions and by economic and social policy.

The chapter also describes the educational background required for the several types of nurse specialists in Mexico. In particular, it explains why nursing specialty certification in Mexico is not conducted the same way as in the United States and Canada. It also explains why it has been proposed to establish only eight certifying councils for the 15 post-technical courses and 10 nursing specialties existing in Mexico.

Finally, the Nursing Specialty Certification Project (Proyecto de Certificación de Especialización en Enfermería) is described, including its purpose, goals, and stages of development.

Historical Factors

In Mexico, a post-technical course is a one-year course that can be taken by a nurse technician. A specialty course, one to two years in length, is intended only for baccalaureate nurses. The evolution of post-technical courses and nursing specialties has been linked to technical advances in medicine, as well as to the need to prepare nursing administrators and to formalize the teaching of nursing.

The first post-technical nursing specialty in Mexico was Sanitary Nursing (1937)[1] . Eventually, the following courses were added: Pediatric Nursing (1941)[2], Nursing Anesthesiology (1942)[2], Surgical Nursing (1943)[2], Community Health Nursing (1949)[2], Obstetric Nursing (1953)[3], Psychiatric Nursing (1953)[3], Nursing Education (1952)[2], Hematology (1953)[2], Management for Ward Nurse Chiefs (1955)[2,3], Urology (1964)[2], Cardiological Nursing (1966)[1], and Plastic Surgery (1973)[2].

Parallel to the institution of these post-technical courses, there was a rapid development of institutionalized medicine in Mexico. As a consequence, demand for well-prepared nursing personnel increased, and many health institutions implemented new post-technical and specialty courses in order to prepare their personnel for the new requirements.

Some of these newer post-technical courses developed were Intensive Care, Oncology, Geronto-Geriatrics, Mental Health, Primary Care, Nephrology, Peritoneal Dialysis, Maternal-Child Care, and Parenteral Nutrition.

At the same time that the newer courses were implemented, others, such as Anesthesiology and Obstetrics, became medical specialties and disappeared as nursing specialties.

Current Status of Specialty Certification

Education and Training of Nursing Specialists

If we consider certification as a voluntary, formalized process with set standards for meeting specialty criteria and that has as its outcome the assessment of competence in the field of nursing for which certification is sought, no such certification exists in Mexico either for nurses or nurse specialists.

The Labor Ministry (Secretaría del Trabajo), a branch of the Mexican Federal Government, is the only organization that, as established in the Federal Labor Act, compels all employers, including those who offer health services, to train their workers and to give them certificates for their acquired skills if they pass a test. Training courses are mandatory.

On the other hand, although a formal process of certification does not exist, both public and private health institutions supervise their personnel in order to detect training deficiencies and prepare courses designed to improve their skills. Thus, many nurses have taken training courses in several areas of nursing.

The duration of training courses varies from one week to two years. Each institution offers these programs according to its own assessment of need and public demand. These courses are offered both by health institutions and educational institutions. In some cases, nurses finance their own courses; in other cases, the courses are paid for by the institutions.

Presently in Mexico, there are two types of nursing specialists: post-baccalaureate nurses and post-technical nurses. Their academic backgrounds are as follows:

Post-baccalaureate nurse specialists:

- Twelve years of basic education (six years of elementary school, plus three years of junior high school, plus three years of senior high school);
- Four years of college nursing studies;
- Community service experience ranging from six months to two years; and
- One to two years of studies in a specific area of nursing.

Post-technical nurse specialists:

- Nine years of basic education (six years of elementary school plus three years of junior high school);
- Three years of nursing studies;
- Community service experience ranging from six months to two years; and
- One year of studies in a specific area of nursing.

Nursing Specialties: Currently Designated and Proposed

At present, 15 post-technical programs (See Appendix A) and 10 "nursing specialty" programs (See Appendix B) are offered by six higher education institutions in Mexico. However, only eight of the programs qualify as specialties according to the criteria established by the International Council of Nurses (ICN; See Appendix C) and by the Mexican Specialty Certification Group (Grupo de Certificación de Especializaciones Mexicanas). Therefore, it has been proposed to establish Certification Councils only for the following eight specialties:

- Geriatric and Gerontological Nursing
- Intensive Care Nursing
- Mental Health Nursing
- Nurse Educator
- Nursing Administration
- Pediatric Nursing
- Public Health Nursing
- Surgical Nursing

The remaining seven specialties will be certified by the Councils already listed above. For example, the Council for Certification on Intensive Care Nursing will certify Cardiology Nurses; the Council on Public Health Nursing will certify Primary Health Care Nurses and Maternal-Child Nurses, etc.

Future Developments

In order to guarantee that specialized nursing practice is conducted by personnel whose knowledge and skills are adequate to the needs of the population and that specialized nursing practice is conducted according to the scientific and technological state of the art, the National College of Nurses (Colegio Nacional de Enfermeras, or CNE), by means of its National System for Nursing Accreditation and Certification (Sistema Nacional de Acreditación y Certificación de Enfermería, or SNACE), will develop the Nursing Specialty Certification Program.

Objectives of the Nursing Specialty Certification Program

- To increase the number of nursing professionals.
- To standardize specialized nursing practice.

- To ensure that institutions will hire only nursing personnel who have complied with a specialty certification program.
- To establish equivalencies for professional practice among North America Free Trade Agreement (NAFTA) signatory countries.

Stages of Development

The above objectives will be attained in the following stages:

First Stage: Formation of the CNE Directing Committee on Nursing Certification. This will be done by the SNACE Coordinating Committee. This committee's tasks will be:

- To determine the functions and responsibilities of Directing Committee members.
- To define the structure and functions of Specialty Certification Councils.

Second Stage: Preparation of the Specialty Certification Program by the Directing Committee. This program will be developed based on social needs, its purposes, policies, objectives, definitions, and the nursing specialties subject to certification.

Third Stage: Development of certification standards and procedures. The tasks of this stage will be:

- To integrate work groups for each specialty.
- To prepare a draft document for discussion that includes professional profiles, standards, and certification procedures.
- To request help and advice from experts on standards development and from nursing service clients.
- To sponsor national workshops for discussion and revision of the drafted standards.
- To field-test the standards.
- To submit the resulting standards to the SNACE Coordinating Committee for final approval.

Fourth Stage: Implementation of the certification process. The tasks of this stage will be:

- To inform the nursing community about the procedure for certification of specialties.
- To establish an agreement with health and educational institutions that require them to hire only individuals who are legally certified.
- To certify nursing personnel according to the following time line: From 1997 until the year 2010, those nurses with post-technical and specialty training in the areas previously mentioned will be certified. Beginning in 2011, specialty certification will be exclusively for post-baccalaureate specialties.

Fifth Stage: Evaluation of and feedback on the certification process, to be conducted by the Directing Committee. The tasks of this stage will be:

- To supervise and counsel the Specialty Certification Councils on the development of the process.
- To prepare and administer a program for the evaluation of the certification process.
- To fine-tune the certification process according to the evaluation results.

Related Activities

The CNE also is working on another project for nursing regulation. Its goal is to reach a professional development level that is equivalent to that of nursing personnel in the United States and Canada. This will be accomplished by establishing equivalent requirements to facilitate exchange and mobility of nursing professionals among the three countries.

Appendix A

Post-Technical Nursing Programs in Mexico

Program	Duration (Months)
Nursing Services Management	6 to 10
Administration and Teaching	10
Care of the Critical Patient	10
Primary Health Care Nursing	10
Intensive Care Nursing	9
Surgical Nursing	10
Public Health Nursing	10
Mental Health Nursing	10
Cardiological Nursing	10
Geronto-Geriatric Nursing	10
Neurological and Neurosurgical Nursing	10
Oncological Nursing	10
Orthopedic Nursing	10
Pediatric Nursing	10
Psychiatric Nursing	10

Sources:

Division of Higher Studies, National School of Nursing and Obstetrics, National Autonomous University of Mexico, 1994.

Interinstitutional Commission for the Preparation of Human Resources for Health [Services], Ministry of Health, Mexico, 1993.

Appendix B

Nursing Specialty Programs in Mexico

Program	Duration (Years)
Nursing Administration	1–2
Physical Health and Physiotherapy Nursing	1 1/2
Nurse Educator	2
Intensive Care Nursing	1
Nursing Administration and Teaching	1
Pediatric Nursing	1
Surgical Nursing	1
Public Health Nursing	1–2
Community Health Nursing	1–2
Mental Health Nursing	1–2

Source: Curricula for Nursing Specialties, (1995). National School of Nursing and Obstetrics, National Autonomous University of Mexico.

Selected nursing specialty programs are offered by the following universities:

University of Colima School of Nursing

University of San Luis Potosí School of Nursing

Autonomous University of Yucatán School of Nursing

Autonomous Juárez University of Tabasco School of Nursing

Autonomous University of Coahuila School of Nursing

Autonomous University of Nuevo León School of Nursing

Appendix C

ICN Criteria for Designating Specialties

1. A specialty must relate to nursing. It must conform to the general purpose, functions and ethical rules of nursing.
2. The practice of a specialty must be sufficiently complex and advanced. That is, it must exceed the scope of the general practice of nursing.
3. There must be a need as well as a demand for such specialized service.
4. A specialty must focus on a certain population segment with recurrent problems and phenomena that belong to the scope of nursing.
5. The practice of a specialty must be based on a core of nursing knowledge that is constantly growing and improving by means of research supported, advised, and communicated to the general public by existing means.
6. The practice of a specialty must be subject to established teaching rules and practices, congruent with those of the profession and determined by a recognized nursing organization.
7. A specialty must adhere to certification requirements and professional regulations applicable to the generalist nurse.
8. Knowledge pertaining to a specialty must be acquired by means of an approved higher education curriculum that leads to a recognized qualification. The study plan for a specialty must be conducted by a nurse.
9. A specialty must be subject to a certification process determined by a college of nursing professionals or as it is nationally customary for other professions. There must be sufficient availability of human and financial resources to support the certification process.
10. Professionals must be organized and represented by a specialized association or a branch of the national nurses association.

Source:
Affara, F. & Styles, M.M. (1993). Nursing regulation guidebook: From principle to power. Geneva: ICN.

Footnotes

1. Martínez Benítez, Ma. M., Latapi, P., Hernández Tezoquipa, L., & Rodríguez Velazquez, J. Sociología de una profesión: El caso de enfermería (1993). [The sociology of a profession: The case of nursing]. (2nd ed.). México: Centro de Estudios Educativos, A.C.
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3. Jamieson, F.M., Serval, M.F., Suhrie, E.B. & Maza Brito, Ma. E. (1968). Historia de la enfermería [History of Nursing]. (6th ed. en Español, pp. 375-376). Mexico: Interamericana.
4. Trilateral Initiative for North American Nursing (July 20, 1995). Glossary of Terms.

Nursing Specialty Certification in the United States

Carolyn K. Lewis, PhD, RN
American Nurses Credentialing Center

Janice Camp, MSN, RN, COHN
American Board of Nursing Specialties

Jane Rothrock, DNSc, RN, CNOR
Nursing Organization Liaison Forum

Executive Summary

- First certification examination: American Association of Nurse Anesthetists (1945).
- American Nurses Association (ANA) administers first certification examinations for the pediatric nurse practitioner, the gerontological nurse, and the psychiatric and mental health nurse (1974).
- American Nurses Association (ANA) Commission on Organizational Assessment and Renewal recommends establishment of a separately incorporated center through which ANA would serve its own credentialing programs (1989).
- Health care reform initiatives focus on state rather than national control of the system, posing new opportunities and threats.
- Basic regulation of nursing is best achieved through licensure and certification.
- Regulatory mechanisms may be public (licensure) or private (certification).
- Hybrid regulations exist, such as some state laws (public) mandating national (private) certification for prescriptive authority.
- There are two levels of specialty certification: basic (often called generalist), which attest to proficiency within a clinical or functional specialty area of nursing and advanced practice, which measures competency for entry into practice at the advanced level, e.g., as a nurse practitioner.
- As certification moves from being solely peer recognition to a basis for licensure, the importance of constructing and administering psychometrically sound, legally-defensible examinations increases.
- The value of a credential is enhanced when testing methodologies can adhere to the external standards of testing experts, i.e., when outside accreditation of the testing program can be attained. Increased exposure to litigation is an external threat for credentialing organizations.
- Health care is embedded in a cultural context; therefore, certification programs must first address national needs.
- Differences in educational preparation and specialty practice requirements in participating countries must be reconciled for standardization to occur and ensure the highest quality of nursing care in every part of North America.

Note: The authors of this paper have drawn primarily on their personal knowledge of the American Nurses

Credentialing Center (ANCC)[1], which is a subsidiary of the American Nurses Association (ANA)[2], the Nursing Organization Liaison Forum (NOLF)[3], the American Board of Nursing Specialties (ABNS)[4], and the National Specialty Nursing Certifying Organizations (NSNCO). Together, these organizations represent the majority of certified nurses in the United States.

Historical Factors

The Origins of Specialty Certification in the United States

The credentialing of nurses has emerged and will continue to mature within the context of a changing climate for health care. This environment has changed dramatically in the last few years in the United States. Today, more than ever before, patients in all settings, hospitals, communities, and homes, require specialized care by well-qualified nurses (Hartshorn, 1991). As health care has become more specialized, nursing practice has similarly become more specific and specialized. Care by well-qualified, specialty nurses has become increasingly important, as have the education and practice qualifications of the individual nurse.

The process of credentialing may be privately or publicly conducted. Private regulation of professional practice evolved from the decision of doctors in the early 1900's to ensure standards, values, and safe practice for their patients. Private regulation occurs in voluntary settings, with members of the profession using expert panels to define the scope and standards of practice and to determine certification eligibility criteria and evaluation methods to ascertain adequate practice knowledge and skill. Self-regulation carries the risk that professions may be perceived to be protecting the inept professional from external scrutiny. On the other hand, public regulation via governmental bodies, usually in the form of licensure, is based on the authority of the state to protect the public welfare under the authority vested in the state through both civil and criminal statutes. This form of regulation is more public, external, and mandatory.

The role of certification in the nursing profession has become complex. Certification can be used for entry into practice, validation of competence, recognition of excellence, and/or regulation. It can be mandatory, academic, or professional. As one can readily surmise, all of these qualities make an explicit definition of certification virtually impossible (ANA, 1979). The meaning and intended purpose of certification is often determined by the particular specialty. For example, certification for advanced practice nurses[5], such as nurse practitioners[6] who provide nursing and primary health (medical) care, is used for entry into practice; whereas, basic certification in a specialty area of practice often is used for validation of competence or recognition of excellence.

Voluntary certification was introduced to nursing in 1945 by the American Association of Nurse Anesthetists (AANA)[7]; however, it did not become a recognizable part of credentialing in basic nursing practice until the 1950's, when the American Nurses Association (ANA) began to explore ways to formally recognize achievement, performance, and education in nursing. In 1966, a major turning point in the development of nursing certification occurred when ANA's structure was modified to allow for the formation of the Divisions of Practice. A bylaws revision provided for a certification board for each division that would develop the division's specialized criteria for the recognition of professional achievement and excellence in its area of concern. In 1968, a concept paper on the meaning of certification was widely circulated and led to the drafting of guidelines for the certification process the following year. Much of the attention in these early days centered on methods to provide formal recognition to qualified clinical nurse specialists (CNS's)[8], registered nurses who, through study and supervised practice, have become expert in a defined area of knowledge and practice in a selected area of clinical nursing (ANA, 1994a).

The U.S. government did not act on professional certification until 1971, when the Department of Health, Education and Welfare (DHEW) proposed a study on the feasibility of a system of national certification for health professionals. The study was initiated by the Institute of Public Administration (IPA) and released in 1974. The report concluded that a system of national certification was appropriate and should be based on the collaboration of certifying bodies and should not involve government control (ANA, 1979, October).

The DHEW definition of certification formulated in 1971 was:

> Certification is the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by an agency or association. Such qualifications may include: a) graduation from an approved or accredited program; b) acceptable performance on a qualifying examination or series of examinations; and/or c) completion of a given amount of work experience (ANA, 1979, October).

By early 1972, three ANA practice divisions had delineated their guidelines for certification. In 1973, the ANA

initiated a certification program based on the ANA standards of practice, education and service. The original purpose of certification was to provide for the recognition of professional achievement and excellence in the certified area. It was designed to be a voluntary process that would serve the profession as a self-regulatory mechanism, define nursing practice as it evolved, and hold certified members accountable for practice according to the standards set forth for specific practice areas. Certification was also seen as serving the public by demonstrating that the profession offered its members a means of showing that they had met the highest standards of the profession.

During 1973, ANA entered into a contract with the Educational Testing Service (ETS)[9] for assistance in developing certifying examinations including services for test administration and test scoring. The certification boards for each practice division were established. In August 1993, ANA met with the Federation of Specialty Organizations, representing 26 organizations. The meeting centered on the ANA program of certification as well as other certification programs and their relationships. The ANA Center for Credentialing Services, a staff unit, was originally established as the Department of Credentialing in 1975.

The formal inception of credentialing within ANA began in 1974 when 691 candidates took certification examinations in three nursing specialties: pediatric nurse practitioner, gerontological nursing, and psychiatric and mental health nursing. Two of the three initial ANA certifications were basic (generalist) specialty certifications, with eligibility criteria based primarily on an experience requirement in a specific area of practice. The basic areas of certification focused on more broadly defined areas of practice in a specialized area.

Also in 1974, ANA offered its first advanced practice certification to nurse practitioners. A component of the eligibility criteria for this advanced practice certification was that the nurse have additional, formal educational preparation[10], but did not specify a baccalaureate[11] or master's degree[12]. In 1976, the first ANA clinical nurse specialist certification exam was offered. The purpose of certification remained the same, but criteria for specialist certification included a plan for a master's degree educational requirement.

While ANA originally conceived of certification as a demonstration of professional excellence and as a statement to the public, an additional purpose came from political and legal regulatory pressures, leading to the utilization of the credential as a requirement for entry into expanded specialty practice. This has been especially true for the nurse practitioner, for whom certification requirements have been incorporated into the licensing statutes and regulations of various Nurse Practice Acts. This issue has important implications for certification, for when certification for advanced or specialty practice is required for entry into practice or for reimbursement, then certification is no longer voluntary. Certification also changes from a professional recognition program, as originally conceived by the professional association, into a regulatory requirement mandated by the public.

As health care has become more and more complicated and nursing increasingly specialized, professional certification has become one mechanism to define the appropriate and safe practice privileges of differently qualified registered nurses. Accordingly, in recent years, there has been an increasing number of nurses seeking certification as a means of demonstrating their competence in specialty practice. More than 350,000 of the 2.2 million nurses in the United States are today certified in a particular specialty. This number has doubled in the last five years and it appears that it will continue to escalate.

Fueled by the proliferation of specialized areas of practice, a highly mobile population, and rapid technological developments, there is also a rising social demand for nationally accepted means of identifying competence in persons practicing in health care-related fields, including nursing. In response to this demand, there has been a tremendous growth in the number of certification programs. The initiation of health care reform, recognition of private certification by state regulatory agencies, and third-party reimbursement for certified advanced practice nurses are factors in the continued growth in certification programs.

Prior to 1989, the term certification had no consistent meaning within the nursing community, since each organization developed its own certification process. No national standards existed for nursing certification. At the same time, the growth, and growing importance, of certification were inviting close scrutiny from the nursing community as well as regulatory bodies, employers and academic institutions.

In order to enhance the value of their credentials, certifying agencies increasingly seek accreditation of their processes and governance by independent organizations, such as the National Commission for Certifying Agencies (NCCA; See Appendix A). The logic is threefold. First, accreditation establishes that credentialing standards are not under the control of any other association or organization. Secondly, with the increasing economic value of professional certification, accreditation insulates the parent organization from litigation instigated by those who are precluded from sitting for an examination, who

have failed or who have lost their credential through disciplinary actions. Clearly, a credentialing agency that has submitted its psychometric standards to rigorous independent scrutiny and established its independence in governance and financial matters stands on much firmer ground in this litigious society than one that self-validates. Lastly, qualified accreditation is critical in resolving conflicts with government agencies, not the least of which is the Internal Revenue Service.

During the last two decades, the nursing profession has seen a proliferation of certification programs. The mechanism for professional certification has largely remained voluntary and under the direction of private organizations. In the late 1980's, the Josiah Macy, Jr. Foundation determined that a shortage of nurses was a critical problem for quality health care. With a strong history of funding innovations in medical education and services, the foundation began to explore whether it could assist in addressing the shortage of nurses and advancing the role of nurses in the health care system. Representatives of the Macy Foundation met with leaders of the nursing profession to explore ways of enhancing the professionalization of nursing through a unified approach to strengthen the process of certifying nurse specialists.

The discussion focused on the numerous certification programs in nursing and the lack of uniform, consistent certification criteria. As a result, specialty nursing certification was becoming confusing to the public and employers, as well as to nurses. It was determined that one solution for improving the professionalization of nursing was to set national standards for specialty certification of nurses. In March 1988, a steering group proposed the development of an "umbrella board" as a mechanism to standardize criteria for certification. In May 1988, this committee became the National Committee for Promotion of Quality of Specialty Nursing Practice. The group worked with 58 specialty nursing organizations and certification programs to develop consensus standards and a national Board of Nursing Specialty Certification. In February 1991, the American Board of Nursing Specialties (ABNS) was established by eight charter Boards. This group represented approximately 65 percent of the total number of nurses certified in the United States. The mission of the ABNS is to set standards and criteria for the review and approval of nursing certification bodies according to national consensus standards (See Appendix B for ABNS standards).

ABNS is dedicated to assuring consistent and rigorous standards of certifying nursing specialties and accomplishes this mission through a peer-review process. In doing so, ABNS also serves as an advocate for consumer protection, increases the public's awareness of the meaning and value of specialty nursing certification, and enhances the prestige, self-actualization, and professional advancement of certified nurses in the United States.

While the 44 existing certifying organizations had accepted the need for nursing certification to develop a body such as ABNS, there was concern related to the educational standards adopted by ABNS. An educational standard that has been adopted by ABNS requires member certifying organizations to institute by the year 2000 the requirement of a baccalaureate in nursing for general certification and a master's in nursing for advanced certification. The financial and political implications of this requirement posed a major problem for some certification boards; only 8 of the 44 existing organizations initially sought ABNS approval. Since that time, however, membership in ABNS has grown to 14 Boards on Certification representing 178,000 nurses. It is expected that the ABNS membership will continue to increase as the need becomes evident for certification organizations to adhere to national standards so that their credentials are recognized by regulatory agencies, employers, and third-party payers.

The establishment of ABNS is significant in the evolution of the U.S. nursing profession. Nurses who are certified by the specialty organizations that have been approved by ABNS can be assured that their certification meets national consensus standards developed by leaders of specialty organizations, and that their credentials have consistency and meaning to the U.S. consumer.

As nurses graduate from basic educational programs, many are employed on specialty units. However, they often find that their basic nursing education has not prepared them for specialty practice. Once the nurse has some experience and additional education in a specialty field, she/he may voluntarily seek certification to demonstrate her/his expertise in a specialized practice area (Hartshorn, 1991). This credential recognizes the quality in professional practice and continuing education that consumers and employers seek, but the mechanisms for voluntary credentialing in the United States ultimately rest with the nursing profession.

Current Status of Specialty Certification

The Definition and Purposes of the Certification Programs

Criteria to consider when selecting an appropriate level of regulation for professional practice include the risk of harm to the consumer; the specialized education, skills and abilities required for the professional practice; the

level of autonomy, the scope of practice and economic impact; and alternatives to regulations and a determination of the least restrictive consistent with the public safety (NCSBN, 1992).

Successful implementation of voluntary or private regulation of a profession assumes sufficient credibility and support within the profession. Certification is the principal method by which a profession gives formal recognition to an individual who has demonstrated her/his competence in a defined area of specialization in the professional field. Certification is one form of credentialing of health professionals and it customarily resides in the hands of one or more voluntary organizations in the particular field. The certification program provides a nurse with an opportunity to demonstrate that her/his knowledge and skills as a professional nurse surpass the minimum required for licensure. Certification validates, based on predetermined standards, an individual registered nurse's qualifications, knowledge, and practice in a defined functional or clinical area in nursing.

At the basic level, certification is a method of demonstrating competence in an area of nursing practice and of conferring peer and public recognition upon those practitioners who have achieved some proficiency in their practice. However, for the advanced practice nurse, e.g., nurse practitioners, certification is often used for entry into that practice level. The main objective of certification in nursing is to assure public safety. Certification recognizes specialty training, enhances prestige and self-actualization, and, in some cases, serves as a criterion for financial reimbursement. It may also foster an enlarged role within the employment setting or lead to independent practice. Because certification of nursing practice signifies attainment of specific criteria and knowledge in a specialty field, certified nurses comprise a minority of the professional nurse population.

Professional certification and licensure are two mechanisms for assuring the public of competent professional practice. Adherence to rigorous credentialing standards is a major goal of certifying bodies. Therefore, the development of each examination requires a well-planned, systematic effort that holds to the existing standards of practice in nursing and in measurement methodology.

What is Credentialing in the United States?

Credentialing is a generic term for providing attestation of the credit, confidence or authority that can be safely placed in a person, group or system. This can take the form of licensure, certification, accreditation or registration. Credentialing can be required by statute or used as a term for a voluntary process under the auspices of private sector entities. Credentialing programs protect the public by enabling anyone to identify competent people or systems more readily, and simultaneously aid the profession by encouraging and recognizing professional and institutional achievement.

Certification is a process by which a state regulatory body or a non-governmental agency or association attests that an individual licensed to practice a profession has met certain predetermined standards specified by that profession for specialty practice. Its purpose is to ensure various publics that an individual has mastered a body of knowledge and acquired skills in a particular specialty. Title protection is granted to persons who have met the predetermined qualifications. Those without the title may perform the services of the profession or occupation, but may not use the title.

Recertification is a process that demonstrates the continued competency of certified practitioners. For example, the American Nurses Credentialing Center (ANCC) permits recertification either through the maintenance of a practice requirement within the specialty and meeting a continuing education requirement, or by retesting. The certified nurse must apply for recertification every five years. If the certification lapses, all current eligibility requirements must be met within the specialty and the certification examination must be retaken.

The majority of nursing certifications in the United States are for five years. Certification by the Council on Certification of Nurse Anesthetists and Nursing Administration, Long Term Care (NADONA/LTC) must be renewed every two years. Those that require recertification every three years include the Addictions Nursing Certification Board, Plastic Surgical Nursing Certification Board, American Board of Post-Anesthesia Nursing Certification, American Board of Urologic Allied Health, National Certification Corporation for Obstetric, Gynecologic, and Neonatal Nursing Specialties, and the Nephrology Nursing Certification Board. Organizations that certify for a four-year period include American Association of Critical-Care Nurses Certification Corporation, the Board of Certification for Emergency Nursing, Oncology Nursing Certification Corporation, American Academy of Pain Management, National Board for Certification of Hospice Nurses, Certification Corporation of Pediatric Oncology Nurses, and the Board of Nephrology Examiners, Nursing & Technology (BONENT).

Licensure in the United States is the process by which an agency of state government grants legal permission to individuals accountable for the practice of a profession to engage in the practice of that profession and prohibits all

others from doing so. It also permits use of a particular title. Its purpose is to protect the public by ensuring a minimum level of professional competence. Established standards and methods of evaluation are used to determine eligibility for initial licensure and for periodic renewal. Effective means are employed for taking action against licensees for acts of professional misconduct, incompetence and/or negligence (ANA, 1979, March, p. 86).

Registration is a process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency. It enables such persons to use a particular title and attests to employing agencies and individuals that minimum qualifications have been met and maintained (ANA, 1979, March, p. 87).

The Three Phases of Specialty Certification in the United States

Phase I: Designation of a Specialty for Certification

What constitutes a nursing specialty was initially controversial. The growing complexity of the health care delivery system necessitated the increasing specialization of nurses. Dr. Margretta Styles, Chair of the Committee for the Study of Credentialing in Nursing in 1979, proposed a mechanism for nursing specialization including criteria for a degree of homogeneity and quality of a nursing specialty. She noted "as subsystems of nursing, specialties should individually demonstrate the viability and effectiveness of their functional components (practice, education, research, peer review/credentialing) and should in the aggregate evidence a high degree of homogeneity among themselves and a high degree of fit within the total profession" (p. 57). She went on to describe the criteria that would provide evidence that a subsystem was indeed a unique specialty in nursing. These criteria were later adopted as the ABNS standards (See Appendix B).

As an example, ANCC has established a uniform process for developing criteria and determining conformity to both internal and external standards. The peer review process incorporates procedures that are clearly articulated and uniformly applied; uses criteria that are measurable, unbiased, and reflective of contemporary nursing practice and education; relies on instruments that are technically sound; and provides an ongoing mechanism for evaluation and constructive change. ANCC certification examinations reflect practice in those nursing specialties recognized by the ANA Congress of Nursing Practice that have an approved scope and standards of practice (See Appendix C). Nursing standards provide authoritative measures for determining the quality of nursing care.

Phase II: Development of Certification Examinations

Certification in a particular field is typically awarded on the basis of evidence that individuals are prepared to practice their professions at a specified level. A sound testing program can be a major component of the certification process when used in conjunction with other evidence of achievement, such as documentation of satisfactory work experience or fulfillment of educational requirements. An examination, when used within the context of the certification process, can help to make the certification decision fair, objective, and reflective of the knowledge and skills necessary to practice a profession at the specified level.

It is important to establish the purpose of the testing program within the total certification process and to determine the relationship of the information provided by the test to other program elements. When this is done, experts in the certifying profession and experts in testing should collaborate in planning and implementing a sound certification testing program.

Generally, design and development of such a program will require two to three years, if the program is to include all the elements deemed essential by the testing profession and considered to contribute most to the quality and effectiveness of a program. These elements are the foundation of a certification testing program that is technically sound and effective (ACT, 1988).

Certification examinations also reflect practice in a particular specialty. For ANCC examinations, a specialty must have published a scope and standards of practice. Through the scope of practice statement, nursing care is defined and developed by nurses, and nurses have responsibility for and are accountable for its quality. Nursing standards provide objective measures for determining the quality of nursing care that a client receives. An especially important foundation for a certification examination is the scope of practice statement, which provides a description of the knowledge a nurse must have to be effective at the certified level of performance.

Once the definition of the specialty and scope of practice and the standards of practice for a field are defined, test development begins. The process as defined by the American College Testing Program (1988) is:

Program Plan

The certifying agency and the testing organization jointly plan all steps necessary to establish and administer the testing program. This plan specifies who is responsible for each task and the timeline for accomplishment. Short-term and long-term activities are outlined, and schedules are prepared for all program elements.

Role Delineation/Job Analysis Study

The content of a certification test must reflect the specific level of practice for which a credential will be awarded. For example, the knowledge and skills measured in an examination for certification of entry level practitioners should differ from those measured in an examination for certification of practitioners in advanced or specialty practice. Testing at the appropriate level of practice requires defining the knowledge and skills necessary for practice. This can be done through a logical analysis of professional practice and an empirical role delineation or a job/task analysis study. Such a study provides essential evidence of content validity by supporting the job relatedness of the certification test. When this study has been completed, test specifications can be developed.

Test Specifications

To allow valid inferences about the level of knowledge and skills a candidate for certification possesses, the test must reflect the knowledge and skills identified as necessary and important to that practice. For each form of the test to provide scores that can be interpreted in the same way, each form must include items that test the same knowledge and skills in proportions that reflect the importance attributed to them in the role delineation or job analysis study. A table of specifications is developed to prescribe the construction of the test. These specifications are used to develop test items that form a pool from which comparable, content parallel forms of the test can be assembled.

Test specifications also describe item and test format, test length, design of test booklets and answer sheets, and design of score reports. The decisions made during the development of test specifications are critical to the quality of the testing program. Therefore, the collaboration of the certifying agency and testing experts is especially vital during this phase of test development.

Item Development

The basic building block of any test is the test item. In addition to representing the knowledge and skills prescribed in the specifications, items must be technically sound. The item development process begins with the training of content experts to develop technically sound test items. This training helps content experts not only to write items, but to review items written by others for accuracy, significance and conformity to test specifications. Testing experts then review the items for technical soundness, absence of apparent bias, and editorial consistency. Items that meet all of the criteria are placed in an item bank and are available for use in examinations.

Item Banking

Test items are maintained in a bank that includes the items and the data gathered from each use. Ideally, this is a computerized item bank that allows easy access, retrieval and revision. Items in the bank are reviewed regularly by content experts to ensure that each item reflects current practice. Outdated items are eliminated from the bank and are regularly replaced with new items that reflect current practice.

Pretesting

Because the decisions that are made in part on the basis of certification test scores are so important, a certification examination should be composed only of items that have acceptable statistical characteristics. Generally, only about 55 to 65 percent of all newly developed items have the statistical characteristics that meet the specifications for an examination. Pretesting is a method used to obtain information about the characteristics of new items before they are used to compute candidates' scores in an actual form of the test. In pretesting, new items are administered to examinees like those who take the certification examination, but the times do not contribute to examinee scores or affect certification decisions. The results of statistical item analyses are used to identify any items that may be flawed and need additional attention. This process helps in developing tests that are unambiguous and fair to examinees because poor quality items can be excluded. Such tests are also expected to be more reliable; that is, the pass-fail decision can be made with greater confidence.

Test Assembly

Only test items that have survived content review, measurement review and pretesting are suitable for inclusion in an actual form of a certification test. Items are selected according to the test specifications and assembled into a test form. Careful attention is given to the format of the test and other production characteristics to ensure that examinees will not be distracted during the testing session.

The assembled test then undergoes final review by content experts, who examine the test for adequate and appropriate representation of the specified knowledge and skills. When the test has been reviewed, test booklets are prepared.

Registration

A handbook is prepared and distributed to potential examinees. This handbook provides information about the purpose of the testing program; the content outline of the test; eligibility requirements for application; proce-

dures to be followed at test administration; and application fees, deadlines and procedures. Notices of acceptance for testing are mailed to the candidates upon receipt of application materials. These notices indicate the location of the test center and the time at which candidates should report to the test center.

Test Administration

Conditions for test administration are standardized so that all examinees take the test under the same secure circumstances. Special testing needs, such as those of examinees who are disabled, also are accommodated.

Equating

No matter how carefully any two forms of a test are constructed, they are likely to differ somewhat in difficulty. When test forms have unequal difficulties, a larger number of candidates will pass an easier test than a harder test, even when the proficiency of the two groups is equal. So that no candidate is penalized for taking a more difficult form of the test or rewarded for taking an easier form, a statistical adjustment is made. This adjustment is referred to as equating; it compensates for any unintentional differences in the difficulty of test forms.

Scoring and Analysis

After a test has been administered, it is scored by comparing each examinee's answers to a correct answer key. A preliminary item analysis is then conducted to detect any items having questionable performance. The results of the item analyses are reviewed by content and testing experts, so that key errors or item ambiguities can be detected and resolved before final scoring.

Passing Score Determination

The passing score for a certification test should reflect the level of performance that is minimally acceptable for the certification award.

Several methods have been developed for establishing passing scores. Each of these methods depends on the systematic judgment of content experts as to what constitutes acceptable performance on the test. These content experts must represent recognized perspectives in the profession.

Score Reporting

Score reports are prepared expeditiously for the candidates and the certifying agency. Each candidate's score report summarizes, clearly and directly, the candidate's performance on the test. Preferably, the score report of each candidate who has failed the test specifies the area(s) of knowledge or skill in which the candidate has been determined to be deficient. Reports to the certifying agency summarize the performance of individuals; of the candidate group as a whole; and of relevant demographic subgroups, such as those defined by sex, geographic region and educational level.

Security

To protect the confidentiality of testing materials and information about candidates, a high level of security is enforced at all stages of examination development, administration and processing. Developmental materials are kept in secure storage when not in use and are destroyed immediately after their usefulness has ended. Only authorized individuals have access to testing materials, and careful records of the custody of these materials are kept at all times. When confidential materials are shipped, only secure carriers who maintain custody records are used.

Public Information

A sound certification testing program gives applicants all the necessary information about the certification process. Applicants are provided information about test content, length, and format; test application and administration procedures; and test score interpretation. Ideally, a full-length sample test with items comparable to the actual test is made available to the candidates. Those who use the test results, candidates as well as the certifying agency and other score recipients, should be given information about the appropriate interpretation of test results, valid inferences that can be made about candidate performance, and proper and improper uses of the test scores.

Program Evaluation and Improvement

Evaluation of the certification testing program is an ongoing process. Content experts and testing experts jointly review the program regularly to ensure that the original purposes of certification are being met and to identify and institute improvements that may further enhance the program.

Innovations and Technology of the Future

Given the rapidly increasing capabilities of technology in education and testing, a sound certification program will provide for an ongoing program of research and development that will examine the potential applicability of such technology in the certification process. Such efforts are necessary if a certification program is to keep abreast of

current and future developments in the field of testing (ACT, 1988).

Most nursing certification programs in the United States are guided by these basic principles. As an example, ANCC's examination development is guided by two statements. The first is the ANCC "Statement of Philosophy of Credentialing in Nursing" (See Appendix D). This statement defines views of the nature and role of credentialing programs in the nursing profession. The second is the Standards for Educational and Psychological Testing (1985) developed jointly by the American Educational Research Association, the National Council on Measurement in Education, and the American Psychological Association.

Any certification examination program comprises two broad categories of activities:

- Test development tasks focus on producing the test form and include developing the test content outline; training item writers; writing, editing, and reviewing test items; maintaining the item bank; assembling the test; reviewing the camera-ready copy of the test; and setting a passing score.
- Operational services focus on the administration of the test and include printing the examination and answer sheets; establishing test sites; hiring and training test center personnel; shipping the examination booklets; administering the examination; scoring the answer sheets; conducting a key validation; equating test scores; printing and distributing candidate score reports; and providing basic statistical data.

Certification programs have a variety of mechanisms for development of test items for the certification examination. For example, ANCC has 26 test development committees (TDC's), which are supported by the Measurement Services unit consisting of two full-time, paid psychometricians, two editors, and an administrative assistant. Each six-member TDC is responsible for one certification examination. These volunteers are certified nurses who are content experts in their specialty field, and typically represent a variety of practice settings and educational backgrounds. Each TDC drafts the test content outline (TCO), assembles the test items, sets eligibility requirements, reviews new questions, and sets the passing scores for the particular examination. The work of the TDC is augmented by another 85 volunteer item writers who write new test questions for the examinations. Measurement Services has a workshop each year to provide intensive training for all new item writers. One of the most important steps of any testing program is the development of the test content outline. The TCO defines the content domains from which questions will be selected for the examination. It both defines and defends the content validity of the examination. To allow valid inferences about the level of knowledge and skills a candidate for certification possesses, the test must reflect the knowledge, skills, and abilities (KSA) identified as necessary and important to that practice.

The scope and standards of practice statements in a specialty are particularly important in developing the TCO. Each TDC draws heavily on the scope and standards in determining the content topics, nurse roles, definitions, and other knowledge to be covered in the TCO and the examination.

Two methods are used by most certifying agencies to develop a TCO. One is a logical analysis which utilizes existing knowledge about a specialty as the basis for specifying job requirements. Specifications are typically formulated by experts, who have considerable practice-related experience and knowledge. Logical analysis selectively focuses on relevant aspects of a job and the results are clearly interpretable within a conceptual framework.

Another approach to developing a TCO involves a role delineation study (RDS). An RDS is typically used in conjunction with a logical analysis in developing the TCO. In this approach, a logical analysis is used to develop a list of practice activity statements. Then, a survey instrument (questionnaire) is developed and administered to obtain data from a large sample of nurses on the relative frequency and importance of each activity. The resulting data can then be analyzed and the results used to develop a new TCO or modify an existing one.

Typically, a TCO includes an outline of the content topics and subtopics that comprise the domain of knowledge to be tested. It also assigns the weight to be given to each, which is expressed as the number of items from each topic and subtopic that will appear on the test. Each form of the test must follow the TCO exactly, so as to ensure that the content of the test is parallel from one year to the next. This allows candidate scores to be interpreted in the same way for each form.

The TCO is required for the test to meet the Standards for Educational and Psychological Testing. The TCO forms the basis for an item classification system that is used to organize the item bank and to make item writing assignments.

When a TCO is first developed for a new examination, or when a TDC elects to revise extensively an existing TCO to reflect changes in practice or candidate eligibility requirements, Measurement Services staff assist the

TDC members in developing a new draft. The resulting draft TCO will undergo extensive review by the TDC, the executive committee of the ANA council for that nursing specialty area, and outside reviewers selected by the nurses on the TDC. Usually, three or four drafts are needed to produce a final version. The entire process takes about four to five months from the first meeting to the final version of the TCO.

Phase III: Certification/Recertification Process

The process of certification and recertification may vary depending on the certifying agency. However, from the viewpoint of the candidate interested in certification, four principal steps comprise the certification process:

Application and Determination of Eligibility
The candidate submits an official application for determination of eligibility; i.e., that all education, experience, and licensure requirements are met.

Testing and Assessment of Knowledge
A roster of eligible candidates is sent to the testing agency, which then makes arrangements for the administration of certification examinations. After the examination is taken, the testing agency completes the scoring and sends the results to the certifying agency and to the individual.

Certification
Successful candidates are notified on behalf of the Boards on Certification of their official certification, which is valid for a specified period (five years for ANCC certifications). A letter and certificate are sent to recognize the certification.

Recertification
ANCC-certified nurses receive informational materials relevant to the recertification process when they are first certified/recertified and again approximately six months prior to the expiration of their certification/recertification. Most certifying agencies give nurses the option of recertification by examination or by continuing education credits, the number of hours of which varies by sponsoring organization. Recertification is also valid for a specified period of time (usually three to five years, as established by the individual certifying organization).

The Administrative Elements that Support Certification

Most certification examinations in the United States are paper-and-pencil tests, which are scored by computer. Many certifying bodies are now considering computerizing examinations.

Generally, nursing certification programs in the United States are administered by management firms and/or paid administrative staff and governed by a board of directors that is usually comprised of volunteer nurses from the specialty and often public members. Most certification programs contract with an independent testing service for assistance in developing and administering the certification examination. More sophisticated programs, such as those of the ANCC, have a number of diverse, expert program staff.

To continue with the ANCC example, the administrative staff is accompanied by a structure of volunteers that consists of a seven-member Commission on Certification (COC) and ten Boards on Certification (BOC), which vary in size from 6 to 13 members. The COC implements ANCC's certification activities; sets the broader certification program policies; serves as the final appellate body for certification and recertification candidate appeals; receives, reviews, and comments on proposals from the ANA Congress of Nursing Practice for new certification programs; and provides a mechanism for the systematic evaluation of the certification program.

The ANCC Boards on Certification set the eligibility requirements for certification and recertification in their respective specialty area of practice; set passing scores for certification examinations; certify nurses who meet the eligibility requirements; make policy recommendations to the COC; govern one test development for each certification examination within their area of practice; and serve as the initial appellate bodies for certification candidate appeals.

Other administrative elements that support certification are:

1. preparing and reviewing the camera copy of the test booklet, as well as important control documents, such as the scoring keys;
2. registering candidates, including reviewing applications to determine eligibility, processing payments, notifying candidates of eligibility, and sending the testing company a computer tape containing all candidate information;

3. administering the examination (done by the testing company) which includes establishing the test sites, selecting and training test proctors, and actually administering the exam;
4. validating the key;
5. setting the passing score;
6. controlling quality and security;
7. developing policies for appeals, revocation of certification, handscoring, retesting, and item bias;
8. notifying candidates of test results;
9. maintaining published/publishable lists of certificate holders;
10. notifying certificate holders of expiration dates and changes in eligibility requirements; and
11. conducting public relations and education.

Table 1 presents selected data on nursing specialties in the United States as of mid-1995.

Table 1 Nursing Specialties in the United States

Specialty	Credential	# Nurses Certified	First Exam	Sponsoring Organization
Acute Care Nurse Practioner (NP)[13]†	CS	0[14]	1995	American Association of Critical Care Nurses and American Nurses Credentialing Center (ANCC)
Addictions	CARN	1200[15]	1989	Addiction Nursing Certification Board
Administration	CNA	6,556	1979	ANCC
Administration, Advanced†	CNAA	2,291	1979	ANCC
Administration, Long-Term Care	C	2,700[16]		NADONA/LTC Certification
Administration, Nursing Director, Long-Term Care	CNDLTC	50		American Society for Long-Term Care Nurses
Adult NP†	CS	6,512	1976	ANCC
Adult NP†			1994	American Academy of Nurse Practioners
Ambulatory Post-Anesthesia	CAPA	625[17]	1994	American Board of Post-Anesthesia Nursing Certification, Inc.
Ambulatory Women's Health Care	RNC	528		National Certification Corporation for Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCCOGNNS)
Anesthetist	CRNA	26,000	1945	Council on Certification of Nurse Anesthetists
Cardiac Rehabilitation	C	188	1994	ANCC
Case Management	CCM			Certification of Insurance Rehabilitation Specialist Commission
Childbirth Educators	ACCE	3,600		ASPO/Lamaze
Clinical Trial Coordinator				Associates for Clinical Pharmacologists
College Health	C	1,401	1991	ANCC
Community Health	C	2,328	1975	ANCC
Community Health Clinical Nurse Specialist (CNS)†	CS	358	1990	ANCC
Continence Care	CCCN	4*		Wound, Ostomy and Continence Nursing Certification Board
Continuing Education/Staff Development	C	2,078	1992	ANCC

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Table 1 (continued)	Nursing Specialties in the United States			
Specialty	**Credential**	**# Nurses Certified**	**First Exam**	**Sponsoring Organization**
Critical Care, Adult	CCRN	50,000		American Association of Critical Care Nurses
Diabetes Educator	CDE	6,600[18]		National Certification Board for Diabetes Educators
Emergency	CEN	25,050		Board of Certification for Emergency Nursing (10/6/95 numbers)
Gastroenterology	CGRN	1,800		Certifying Board of Gastroenterology Nurses and Associates, Inc.
General Nursing Practice	C	1,181	1988	ANCC
Gerontological CNS†	CS	662	1989	ANCC
Gerontological Nurse	C	11,063	1974	ANCC
Gerontological NP†	CS	1,931	1979	ANCC
Hemodialysis	CHN			Board of Nephrology Examiners, Nursing and Technology (BONENT)
High-Risk	RNC	178		NCCOGNNS
Home-Health	C	834	1993	ANCC
Home-Health CNS†	CS		1996	ANCC
Hospice	CRNH	980*	1994	National Board for Certification of Hospice Nurses
Infection Control	CIC	2,000	1982	Certification Board of Infection Control
Informatics	C	0	1995	ANCC
Inpatient Obstetrics	RNC	18,677		NCCOGNNS
Intravenous Therapy	CRNI	3,000		Intravenous Nurses Certification Corporation
Lactation Consultant	IBCLC	N/A		International Board of Lactation Consultants Examiners, Inc.
Low-Risk Neonatal	RNC	2,526		NCCOGNNS
Massage Therapist	NMT			National Association of Nurse Massage Therapists
Maternal-Gynecological-Neonatal Nursing[19]	C	60	1976-1979	ANCC
Maternal Newborn	RNC	162		NCCOGNNS
Medical-Surgical	C	29,735	1976	ANCC
Medical-Surgical CNS†	CS	1,868	1976	ANCC
Midwife[20]†	CNM	4,194		ACNM Certification Council, Inc.
Neonatal Critical Care	CCRN	350		American Association of Critical Care Nurses
Neonatal Intensive Care	RNC	6,352		NCCOGNNS
Neonatal NP†	RNC	1,929		NCCOGNNS
Nephrology	CNN			Nephrology Nursing Certification Board

Table 1 (Continued)	Nursing Specialties in the United States			
Specialty	**Credential**	**# Nurses Certified**	**First Exam**	**Sponsoring Organization**
Neuroscience	CNRN	823*		American Board of Neuroscience Nursing
Nutrition Support	CNSN	248		National Board for Nutrition Support Certification
Occupational Health	COHN	5,780*	1973	American Board for Occupational Health Nurses, Inc.
Oncology	OCN	16,000*		Oncology Nursing Certification Corp.
Oncology, Advanced†	AOCN	0	1995*	Oncology Nursing Certification Corp.
Operating Room	CNOR			See Perioperative
Ophthalmic	CRNO	470	1989*	National Certifying Board for Opthalmic Registered Nurses
Orthopaedics	ONC	2,646*	1988	Orthopaedic Nurses Certification Board
Ostomy Care	COCN	4*		Wound, Ostomy and Continence Nursing Certification Board
Otorhinolaryngology and Head-Neck	CORLN			National Certifying Board for Otorhinolaryngology and Head-Neck Nurses
Pain Management	D (PhD) F (MSN) C (BA/BS)	100[22]	1989	American Academy of Pain Management
Pediatric Critical Care	CCRN	1,250		American Association of Critical Care Nurses
Pediatric (General)	CPN	2,711	1989	National Certification Board of Pediatric Nurse Practitioners and Nurses
Pediatric Nurse[20]	C	3,154	1979	ANCC
Pediatric NP†	CS	2,200	1974	ANCC
Pediatric NP	CPNP	4,500		National Certification Board of Pediatric Nurse Practitioners Licensure and Nurses (NCBPNP/N)
Pediatric Oncology	CPON	470*	1993*	Certification Corporation of Pediatric Oncology Nurses (CCPON)
Perinatal Nurse[23]	C	841	1982	ANCC
Perioperative	CNOR	25,234*		National Certification Board of Perioperative Nursing, Inc.
Peritoneal Dialysis	CPDN			Board of Nephrology Examiners
Plastic Surgical	CPSN	243*	1989	Plastic Surgical Nursing Certification Board
Post-Anesthesia	CPAN	4,400[24]	1986	American Board of Post-Anesthesia Nursing Certification, Inc.
Psychiatric/Mental Health Nurse	C	19,121	1994	ANCC
Psychiatric/Mental Health CNS-Adult†	CS	6,028	1977	ANCC
Psychiatric/Mental Health CNS-Child and Adolescent	CS	766	1977	ANCC
RN First Assistant	CRNFA	378	1993	National Certification Board of Perioperative Nursing, Inc.

Table 1 (Continued)	Nursing Specialties in the United States			
Specialty	**Credential**	**# Nurses Certified**	**First Exam**	**Sponsoring Organization**
Rehabilitation	CRRN	10,000		Rehabilitation Nursing Certification Board
Reproductive Endocrinology/Infertility	RNC	447	1989	NCCOGNNS
School Nurse	CSN	1,025*		National Board for Certification of School Nurses
School Nurse	C	145	1988	ANCC
School NP†	CS	297	1979	ANCC
Urology	CURN	291		American Board of Urologic Allied Health Professionals, Inc.
Women's Health NP[25]	RNC	5,730		CNNOGNNS
Wound Care	CWCN	26*		Wound, Ostomy and Continence Nursing Certification Board
Other Nursing Specialty Organizations[26]				
Pain Management		in development		Am. Society of Pain Management Nurses
				Am. Association on Mental Retardation[27]
				Am. Radiological Nurses Association
				Am. Society of Parenteral and Enteral Nutrition
				Barmedical Therapy Nursing Certification Board
				Enterostomal Therapy Nursing Certification Board
				National Nurses Society on Addictions Certification Board
				Soc. of Peripheral Vascular Nursing
Nurses Currently Certified in the United States		**> 354,485**		

Future Developments in the Next Ten Years

Emerging Issues and Trends

With U.S. attention increasingly focused on health care reform, many consumers now expect to be part of their health care process. Guiding legislation and implementation of health care reform is shifting from the national level to the state level. Consumers are represented on many national and state organizations that oversee health care practice, such as the National Clearinghouse on Licensure Enforcement and Regulation (CLEAR), the Council of State Governments, and many others. At the same time, the health care field itself is experiencing rapid and tumultuous change. In this new era, the verification of a health professional's knowledge base is an important and visible issue. The consumer increasingly expects some assurance that the health care provider is properly licensed and, if certified within a specialty, is credentialed by a psychometrically sound and legally defensible process and is able to competently practice the designated specialty.

The roles and responsibilities of nurses also are changing. Economic, legislative and policy changes are heightening the interest in educated and qualified nonphysician providers (e.g., nurse practitioners) and forcing the recognition of the overlap between medical practice and that of other providers. As health care becomes more specialized and cost-conscious, certification becomes one mechanism to inform the public about its caregivers. Moreover, certi-

fication provides potential economic value to the certificant, since certified individuals may be given preference for hiring, promotions and reimbursement, or during staff reductions.

Many external issues affecting certification have arisen in the climate of health care reform. The evolution of nursing practice has produced an ever-expanding body of knowledge as well as a proliferation of nursing specialties. The demand for nurses practicing in advanced roles with greater autonomy has increased. There has been an increase in recognition of advanced nursing for third party reimbursement and prescriptive authority through statutory requirements, regulatory standards, and market-driven strategies. Certification, a major component of credentialing, is an extremely specialized area and one that must be monitored closely due to current issues such as second licensure.

The Future of Specialty Practice: Certification or Licensure?

The issue of nursing regulation through certification versus licensure for advanced practice nurses has been an ongoing issue within the United States. Generally, state licensure boards regulate basic and advanced practice. Certification of specialty nurses began as a voluntary process to recognize excellence in clinical practice; however, today's environment is changing to require certification for the nurse practitioner as an entry-level examination. However, at the 1994 annual meeting, State Board of Nursing (SBON) delegates directed the National Council of State Boards of Nursing (NCSBN) to study the following topics related to nursing practice and education:

1. Perform a study exploring the regulatory, fiscal and political implications of developing a core competency examination for nurse practitioners, with a report to the 1995 Delegate Assembly.
2. Perform a study to identify core competencies of nurse practitioners, with a report to the 1995 Delegate Assembly.
3. Establish a task force to:
   - develop a database of advanced practice credentialing requirements (licensure, recognition, certification, authority to practice) for each member Board with enough specificity for other member Boards to make credentialing decisions;
   - study whether additional mechanisms could be developed to facilitate interstate mobility of advanced practice nurses, with a report to the 1995 Delegate Assembly (Maine BON, 1995).

At the 1995 NCSBN, the following recommendation were passed:

1. That the National Council collaborate with nurse practitioner specialty certification organizations to make significant progress toward legally defensible, psychometrically sound nurse practitioner examinations that are sufficient for regulatory purposes.
2. That the benchmarks for progress shall be established and evaluated by the Board of Directors.
3. That the Board of Directors shall report to the 1996 Delegate Assembly with specific recommendations regarding future actions including the potential creation of a core-competency examination.
4. That if, at any time, the Board of Directors determines that significant progress is not being made, the Board is authorized to conduct a job analysis of entry level nurse practitioners.

Successful implementation of voluntary or private regulation of a profession assumes that there is sufficient credibility and support within the profession. ANCC believes that certification is the principal method by which a profession gives formal recognition to an individual who has demonstrated her/his competence in a defined area of specialization in the professional field. Certification is one form of credentialing of health professionals and it customarily resides in the hands of one or more voluntary organizations in the particular field. The certification program provides nurses with an opportunity to demonstrate that their knowledge and skills as professional nurses surpass the minimum required for basic licensure or practice. Certification validates, based upon predetermined standards, an individual registered nurse's qualifications, knowledge, and practice in a defined functional or clinical area in nursing.

Professional nursing organizations have supported the recognition of the basic specialty nurse and the advanced practice nurse through the mechanism of voluntary certification. An identifiable and unique scope of practice is a key element of specialist credentialing. Many professional reviewers express concern about the use of a public certification process. However, the basic approach is already one of regulation of nursing through licensure and certification.

Expected Challenges

Because credentialing, by its very nature, excludes individuals and institutions unable to meet the established criteria, there will be challenges. The number of suits increases with general litigiousness of the society and the importance of the credential (e.g., in many states, national certi-

fication is required to practice at the advanced level). According to Jacobs (1992), many legal challenges have arisen that could affect credentialing entities, including:

- Denial of the credential on the basis of alleged anticompetitive behavior or perceived violation of the duty of substantive or procedural fairness.
- The necessity of a credential to practice as mandated by the regulatory body.

Jacobs further states:

> Most privately issued credentials provide advantages but are not required. But where possession of such a credential is, in all practicality, a requirement to practice a profession, courts are likely to find an overwhelming economic effect.... However, a plaintiff need not allege that a credential is an absolute necessity in order to issue a challenge that the credentialing program violates the antitrust laws. The allegation that a "legitimate professional interest" was denied has been held sufficient to allege an antitrust injury. (Jacobs, 1992, p. 17)

> All policy-making functions of a credentialing organization should be kept as independent as is feasible from influence or domination by a parent or related organization whose functions include promoting the economic well-being of the profession or field of endeavor. In short, the credentialing organization should be autonomous with respect to all credentialing functions. Indications are that federal antitrust enforcers would also prefer autonomy with respect to administration of credentialing organizations, that is, funding, staffing, and so forth, but there is as yet no clear legal compulsion for administrative autonomy in addition to the more clearly required functional autonomy (Jacobs, 1992, pp. 24-25).

> Although courts may be reluctant to determine whether a particular test actually measures competence, a credentialing organization that can show that objective experts believe that this test is reasonably reliable in testing competence can use this fact to demonstrate the reasonableness of its credentialing program (Jacobs, 1992, p. 20).

Research Needs

A final issue is the lack of data about nurse credentialing and certification. More research and data are needed to address questions pertaining to certification, its effects and benefits for nurses, consumers, health care, and the public good; the relationship between certification and nursing performance; and the relationship between certification and regulation, to name just a few areas of potential study. By providing a baseline picture of a large certified nurse population at the start of the 1990's, the ANCC descriptive study of the ANCC-certified nurse population is a useful starting point for research efforts in this direction.

But, ultimately, what is the appropriate finishing point? A review of the limited literature on nursing certification points to the central issue, which, unfortunately, has not yet been satisfactorily addressed. That issue is: What is the relationship between nursing certification and performance, the relationship between certification and quality of care? Does certification mean that the certified practitioner is more likely to perform proficiently or provide higher-quality care than a noncertified practitioner? This appears to be the expectation within the nursing community and the expectation of society as well. After all, the major reason for certification is the belief that the quality of care delivered by a certified practitioner exceeds the quality of care delivered by a noncertified practitioner, but this expectation has not yet been empirically demonstrated. To strengthen the role of nursing certification and its place within modern health care systems, credentialing organizations need to support research that will study these questions and provide an empirical basis for future recommendations.

Appendix A

The National Organization for Competency Assurance (NOCA)

The National Commission for Health Certifying Agencies (NCHCA) formed the National Organization for Competency Assurance (NOCA) to offer a membership organization in addition to the standard setting and approval functions performed by the commission. NOCA membership is open to a variety of organizations, some of which are not certifying bodies, that are interested in competency assurance issues. Membership in NOCA does not require or involve any review of certification activity nor recognition of a discipline or profession or their certification arrangements. In essence, NOCA is the trade organization for certifying organizations.

The National Commission for Certifying Agencies (NCCA) is now the accrediting body of NOCA. NCCA is the only standard setting body for professional and occupational certification tests; therefore, NCCA certifies the certifiers.

Organizations must apply for accreditation and only those organizations that achieve this recognition are allowed to display the NCCA logo on their promotional literature. A certifying organization can be accredited by NCCA if it demonstrates compliance with applicable accreditation standards, but no organization can claim membership in NCCA because it is not a membership body.

NCCA accreditation demonstrates to consumers and certificants that a certification agency has been reviewed by a panel of impartial experts that have determined that examinations meet the stringent standards of NCCA. NCCA accreditation provides certification programs a means of answering the question heard from consumers, insurers, courts, and employers: "Who reviewed your certification program?" Only about one-third of the 105 members who attended the 1994 annual meeting of NOCA are accredited certification organizations.

Value of the National Commission for Certifying Agencies (NCCA) Accreditation

Because certification increases opportunities for certificants by allowing advanced practice and providing other tangible and intangible benefits, certification has become a burgeoning market. The demand for certification as a validation of competency grows from employers and payers who require certification in job descriptions and for promotion. Many state regulatory agencies are requiring national certification in order to practice in an advanced role.

In order to enhance the value of their credentials, certifying agencies increasingly seek accreditation of their processes and governance by independent organizations. The logic is threefold. First, accreditation establishes that credentialing standards are not under the control of any other association or organization. Secondly, with the increasing economic value of professional certification, accreditation insulates the parent organization from litigation instigated by those who are precluded from sitting for an examination, who have failed or who have lost their credential through disciplinary actions. Clearly, a credentialing agency that has submitted its psychometric standards to rigorous independent scrutiny and established its independence in governance and financial matters stands on much firmer ground in this litigious society than one that self-validates. Lastly, qualified accreditation is critical in resolving conflicts with government agencies, not the least of which is the Internal Revenue Service.

Among the organizations providing accreditation, the National Commission for Certifying Agencies (NCCA), the accrediting agency of the National Organization for Competency Assurance (NOCA), stands out. Its high standards and intensive approval process are unique in the United States. Independent accreditation has much to offer from the professional association perspective. For instance, it affords credibility with legislators and government officials. In the array of competing certifying agencies, an organization with accreditation based on impeccable standards rises far above the crowd.

Appendix B

American Board of Nursing Specialties Standards

1. The specialty for which certification is offered is defined as and subscribes to the overall purposes and functions of nursing.
2. The specialty is clearly defined and distinct from other nursing specialties.
3. The eligibility criteria for certification adhere to the overall licensure requirements of the nursing profession.
4. The specialty is national in scope, and there is an identified need and demand for the specialty.
5. A substantial number of nurses devote most of their practice to the specialty.
6. The certification body has established a collaborative relationship with a nursing specialty association or branch of a parent organization in order to set standards for the practice of the specialty.
7. The certification board is an autonomous body with administrative independence in matters pertaining to certification.
8. There are existing mechanisms for supporting, reviewing, and disseminating research to support the knowledge base of the specialty. Activities within the specialty contribute to the advancement of nursing science. Knowledge of the specialty is research-based.
9. There are educational programs that prepare nurses in the specialty.
10. The certification program is a peer review process that reflects the standards and scope of practice of the specialty and that provides for the validity, reliability, and integrity of the process.
11. Applicants for certification must meet one of the following educational requirements:
    - a minimum of a baccalaureate degree in nursing and a specified educational program in the area of specialty practice;
    - an advanced specialty nursing practice certification that requires a graduate degree in nursing, or the appropriate equivalent, including content in the specified area of specialty practice;
    - the standard either must be currently in effect or planned to take effect as a requirement for new applicants for certification no later than the year 2000.
12. There is a provision for a public member on the certifying board.

Appendix C

American Nurses Association (ANA) Definition of a Specialty

A nursing specialty would be recognized if it:

1. Defines itself as nursing and subscribes to the overall purposes and functions of nursing;
2. Adheres to the overall licensure requirements of the profession;
3. Is national in scope and can identify a need and demand for itself;
4. Is clearly defined and distinct from other nursing specialties;
5. Is organized and represented by a nursing specialty association or branch of a parent organization that sets standards for it;
6. Has standards that reflect a well-defined base of knowledge and are concerned with phenomena within the discipline and practice of nursing;
7. Has existing mechanisms for supporting, reviewing, and disseminating research to support its knowledge base;
8. Has educational programs that prepare nurses in the specialty;
9. Includes a substantial number of the nurses who devote most of their practice to the specialty;
10. Provides for peer review of its members through a specialty certification program.

Developed by ANA Congress of Nursing Practice
Endorsed by ANA Board of Directors, December 1990
Endorsed by ANCC Board of Directors, April 1991

Appendix D

American Nurses Credentialing Center (ANCC) Statement of Philosophy of Credentialing in Nursing

The American Nurses Credentialing Center (ANCC) provides a formal, systematic mechanism whereby individuals and organizations may voluntarily seek a credential that recognizes quality in professional practice and continuing education. ANCC is uniquely qualified to institute a credentialing program because of its preeminent view of national nursing needs and a capacity to convene a broad-based representation of nursing. The ANCC philosophy of credentialing is based upon and is consistent with the adopted ethical codes, policies, standards, and positions on nursing practice, nursing education, and nursing services of the American Nurses Association. The American Nurses Association, the national professional association for registered nurses, has as a fundamental goal the promotion of high standards of nursing practice, nursing services, and nursing education that will safeguard and enhance the health and welfare of the American public.

Authority for credentialing, which includes accreditation, certification and recognition, ultimately rests with the nursing profession as delegated by society. Within the scope of this authority, ANCC, as representative of the nursing profession, determines which individuals and organizations are granted credentials. ANCC accepts accountability as an essential feature of its credentialing authority.

ANCC believes that:

- Beyond the minimum standards established by state government regulation, further credentialing is a means of promoting and recognizing quality in professional practice;
- The educational preparation necessary for professional nursing practice is the baccalaureate or higher degree, one of which must be in nursing;
- Credentialing for professional nursing practice must be congruent with educational preparation at the baccalaureate or higher degree level;
- The contribution and interdependence of those within the health care system require ongoing collaboration;
- The credentialing process must be responsive to societal needs;
- Accessibility to the credentialing process should be facilitated;
- Credentialing programs adhere to national standards for certifying bodies;
- Credentialing programs must provide appeal mechanisms for individual practitioners or agencies in cases of dispute.

ANCC has established a uniform process for developing criteria and determining conformity to standards, both internal and external. This peer review process incorporates procedures that are clearly articulated and uniformly applied; uses criteria that are measurable, unbiased and reflective of contemporary nursing practice and education; relies on instruments that are technically sound; and provides an ongoing mechanism for evaluation and constructive change. Credentialing in nursing benefits both the public and the profession as a process that facilitates communication between health care providers and society. It is an effective mechanism for meeting the public expectation that the nursing profession will regulate itself.

Appendix E

Specialty Nursing Certification Programs in the United States

(list may not be exhaustive)

American College of Nurse Midwives Certification Council

Addiction Nursing Certification Board

American Academy of Nurse Practitioners

American Academy of Pain Management

American Association of Critical Care Nurses

American Board of Neuroscience Nursing

American Board of Occupational Health Nurses

American Board of Post-Anesthesia Nursing Certification

American Board of Urologic Allied Health Professionals

American Nurses Credentialing Center Boards on Certification

American Society of Plastic and Reconstructive Surgical Nurses

Board of Certification for Emergency Nursing

Board of Nephrology Examiners

Certifying Board for Gastroenterology Nurses and Associates

Certification Board for Infection Control

Certification Board of Pediatric Oncology Nurses

Certification of Insurance Rehabilitation Specialist Commission

Council on Certification of Nurse Anesthetists

International Board of Lactation Consultants Examiners

Intravenous Nurses Certification Corporation

National Association of Nurse Massage Therapists

National Board for Certification of Hospice Nurses

National Board for Certification of School Nurses

National Board for Nutrition Support Certification

National Certification Board for Diabetes Educators

National Certification Board For Perioperative Nursing, Inc.

National Certification Corporation for Obstetric, Gynecologic, and Neonatal Nursing Specialties

National Certifying Board for Ophthalmic Registered Nurses

National Certifying Board for Otorhinolaryngology and Head-Neck Nurses

National Certifying Board for Pediatric Nurse Practitioners and Nurses

Nephrology Nursing Certification Board

Oncology Nursing Certification Board

Orthopaedic Nurses Certification Board

Rehabilitation Nursing Certification Board

Wound, Ostomy and Continence Nursing Certification Board

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Footnotes

1 While the ANCC has three credentialing products, specialty certification of nurses, accreditation of approvers and providers of continuing nursing education, and a magnet recognition program for hospitals, as well as one in development for nursing homes, this paper will concentrate on its certification programs.

2 The American Nurses Association (ANA) is the national association for nurses in the United States. It represents the nation's 2.2 million registered nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

3 The Nursing Organization Liaison Forum (NOLF) is an affiliate of the American Nurses Association, which is comprised of representatives of the ANA and other nursing organizations that "have a mission and purpose harmonious with the purposes and functions of ANA [and] have a governing body composed of a majority of registered nurses". It provides for "the discussion of issues of common concern to the nursing profession" and promotes "concerted organizational action on those issues" (ANA 1993, September, p. 26).

4 The American Board of Nursing Specialties (ABNS) was incorporated in 1991 as a national peer review program for specialty nursing certification bodies. Included in its charter are principles and standards developed by the consensus of numerous national nursing leaders and organizations. This effort was motivated by the need for uniformity in nursing certification standards and public awareness of the value of nursing certification programs. ABNS is an advocate for consumer protection by establishing and maintaining standards for professional specialty nursing certification.

5 The advanced practice registered nurse (APRN) is an umbrella term given to a registered nurse (RN) who has met advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required of all RN's. Under this umbrella fall four principal types of APRN's: the clinical nurse specialist (CNS), nurse practitioner (NP), nurse anesthetists, and nurse-midwives (ANA, 1993, August). In 1992, almost 140,000 RN's in the United States reported having the education and credentials to work as APRN's (ANA, 1994b).

6 The 48,237 nurses who fit the description of nurse practitioner (NP) in 1992 had received advanced education at one of the approximately 150 NP programs in the United States that confer a certificate or, more often, a master's degree (ANA, 1994b). At least 36 states require NP's to be nationally certified by the ANCC or a specialty nursing organization. By 1992, about 58 percent of the NP's had been certified by national organizations. The practice area is evolving. "Working in clinics, nursing homes, hospitals, or their own offices, NP's are qualified to handle a wide range of basic health problems. Most have a specialty for example, adult, family or pediatric health care. NP's conduct physical exams, take medical histories, diagnose and treat common acute minor illnesses or injuries, order and interpret laboratory tests and X-rays, and counsel and educate clients.

In 48 states, they may prescribe medication according to state law. Some work as independent practitioners and can be reimbursed by Medicare or Medicaid (federal funding for the elderly and poor) for services rendered. Others work for hospitals, health maintenance organizations (HMO's), or private industry" (ANA, 1993, August).

7 The oldest advanced nursing specialty is that of nurse anesthetist. Most of the 25,238 nurse anesthetists in 1992 held the national certification "CRNA" (certified registered nurse anesthetist) (ANA, 1994b). "CRNA's administer more than 65 percent of all anesthetics given to patients each year, and are the sole providers of anesthetics in 85 percent of rural hospitals. Working sometimes with an MD anesthesiologist, but frequently independently, these nurse specialists work in almost every setting in which anesthesia is given operating rooms, dentist's offices, and ambulatory surgical settings" (ANA, 1993, August).

8 To be a CNS, an RN must have earned a master's or doctoral degree in nursing that confers specialized knowledge, August, skills and training. Usually, the CNS works in a hospital, teaching patients and staff as well as consulting on complex patient cases. In 1992, there were 58,185 RN's who fit this description, 7,877 of whom were nationally certified. Certified CNS's were more likely to be employed than their noncertified peers, and also they were more likely to have a position title of clinical nurse specialist (ANA, 1994b). CNS's are experts in clinical areas of practice, such as mental health, gerontology, cardiac or cancer care, and community or neonatal health. They work in hospitals, clinics, nursing homes, their own offices, and other community-based settings, such as industry, home care, and HMO's.

Qualified to handle a wide range of physical and mental health programs, CNS's provide primary care and psychotherapy. They conduct health assessments, make diagnoses, deliver treatment, and develop quality control methods. In addition to delivering direct patient care, CNS's work in consultation, research, education, and administration. Some work independently or in private practice and can be reimbursed by Medicare, Medicaid, Champus (military insurer), and private insurers (ANA, 1993, August).

9 ETS is one of the many private corporations in the United States that offers contract services for various types of examinations. Both ETS and American College Testing (ACT), the current testing company for the ANCC, offer aptitude tests for secondary school students seeking entrance into colleges and universities. Services can include any or all of the items outlined in this paper under "Development of Certification Examinations". Most organizations certifying professionals use only a portion of the services offered, such as printing the examinations, arranging test sites, and proctoring the examinations.

10 While the ANA has advocated the adoption of the baccalaureate as the minimum educational level for entry into practice in the United States, today there is a variety of educational programs leading to registration as a nurse. All nurses must have completed secondary school before receiving education/training in nursing from a state-approved school of nursing. The program may be a two-year associate (AA) degree program (usually based in community colleges), a three-year diploma (usually hospital based), or a four-year university program (usually leading to a BSN) (ANA, 1994b). All registered nurses (RN's) must pass a computer-adaptive national examination called the NCLEX in order to receive their nursing license.

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11 Although there are variations in educational requirements, generally a baccalaureate-prepared nurse has received nine years of primary education, four years of academic education in a secondary school, and four years at a college or university.

12 "Master's programs in nursing prepare nurses for roles in advanced clinical practice, teaching, and healthcare administration. Typically, they are the equivalent of 1 to 2 years of full-time graduate study, which may often be completed on a part-time basis, after receiving a baccalaureate. There are now about 330 National League for Nursing accredited master's programs. The master's curriculum involves both classroom time and clinical experience for the duration of the program" (AACN, 1994, p. 26).

13 Specialty certifications marked with a dagger indicate advanced practice specialties.

14 Numbers of certified nurses for the American Nurses Credentialing Center are given as of September 1, 1995. They do not include the nearly 14,000 newly certified nurses, who successfully passed the examination on October 7, 1995.

15 Data marked with an asterisk (*) indicate information taken from the 1994 Organization Data Sheet completed by members of the National Specialty Nursing Certifying Organizations (NSNCO).

16 Unless otherwise noted, the numbers of certificants for organizations other than the American Nurses Credentialing Center have been taken from *Your guide to certification* American Journal of Nursing, January 1995, 38-44.).

17 Information provided by the American Board of Post-Anesthesia Nursing Certification, Inc., August 1995.

18 In addition to the number of certified nurses shown, AADE has certified about 3,000 physicians and other health care providers.

19 Subspecialties are offered in Ambulatory Women's Health Care, Nursing Care in Labor and Delivery, Post Partum Nursing Care, and Neonatal Nursing Care.

20 Certified nurse-midwives (CNM's) are the smallest group of advanced practice nurses. Slightly more than 7,400 RN's were CNM's in 1992. They possess an average of 1 year of specialized education beyond nursing school, either in an accredited certificate program, or like NP's, increasingly at the master's level. Two-thirds of the nurse-midwives were certified by national organizations (ANA, 1994b). CNM's provide well-woman gynecological and low-risk obstetrical care including prenatal, labor and delivery, and post-partum care. In 1990, CNM's delivered 148,728 babies, or about 3.6 percent of all U.S. births that year, in hospitals, birth centers, and homes. An ANA meta-analysis of CNM care found that nurse-midwives performed fewer fetal monitors, episiotomies, and forceps deliveries; administered fewer IV's; delivered fewer low birthweight and premature infants; and had shorter patient hospital stays. CNM's have prescriptive authority in more than 33 states (ANA, 1993, January).

21 AAPM has 5,000 members and is comprised of mental health professionals, chiropractors, dentists, podiatrists, nurses, and other healthcare professionals.

22 From 1979-1982, this was called Nursing of the Child and Adolescent with Acute or Chronic Illness or Disabling Condition, and from 1982-1988, it was called Adolescent Nurse.

23 In 1989, the examination for the High-Risk Perinatal Nurse and the Maternal-Child Nurse certifications were combined to form this examination.

24 Data from the American Board of Post-Anesthesia Nursing Certification, Inc., August 1995.

25 Before 1995, this specialty was called OB/GYN Nurse Practitioner.

26 Most of these organizations have indicated that they are developing or will develop specialty certification examinations.

27 In the process of designing both a generalist and specialist certification examination in Development Disabilities Nursing. The multidisciplinary AAMR has about 400 nursing members.

Similarities and Differences in Nursing Specialty Certification in Canada, Mexico and the United States

The following chart depicts an assessment of the status (current as well as known future projections and plans) of certification processes for nurses in Canada, Mexico and the United States. For the purposes of clarity, a very simple, concise, yet clear definition of certification was operationalized to mean that there is a process for certification that is voluntary, formalized, has set standards for meeting specialty criteria, and has as its outcome the assessment of competence in the field of nursing for which the certification is sought. In all three countries, this definition is congruent.

The purpose of certification was elucidated as promoting safe service (nursing care) for consumers and simultaneously recognizing nurses for meeting predetermined standards by which competence could be assessed. This dual purpose is very clear in the United States. Mexico has more of a focus on quality assurance, with the link between quality and validation of that quality more intuitive and conceptual; the United States has identified the need to quantify, through research, this assurance that quality relates to assessment of competence via certification. In Canada, the recognition of the nurse is clearly a purpose of certification, while the reservations regarding quality links and outcomes and safe service are more pronounced. The Canadian certification does not have as a clearly stated purpose consumer protection; thus, the question remains as to whether this could be concluded through deductive reasoning, while not being specifically stated as a purpose of certification in Canada.

Each of the three countries defines specialty nursing as a nursing subsystem wherein a specific body of knowledge is possessed, and there exists practice standards, education for the specialty, and research into the specialty and/or specialty patient populations.

The examination development process is most centralized within the profession in Canada, where the Canadian Nurses Association develops all certification examinations. In the United States, the process is delineated by a number of specialty organizations and/or specialty certification organizations that develop their own examinations. Thus, the process may not be exactly the same for all exams in the United States as they are developed by a heterogeneous group of organizations. Mexico has outlined an examination development process, but this is a future plan and may be hastened and augmented by cooperation and consultation from bodies within the United States and Canada. It is anticipated in Mexico that the examination development process will be under the auspices of the National College of Nurses (Colegio Nacional de Enfermeras, A.C., or CNE).

The three countries also demonstrate similarity in the eligibility criteria to sit for certifying examinations. At the minimum, there is a basic educational requirement, an experience requirement in the specialty practice area, and a commitment to move towards requiring a BSN as the qualifying degree that must be obtained before a candidate may sit for certification. The American Board of Nursing Specialists has clearly set the direction for this as a goal of certification in the United States (although not all organizations or certifying bodies have yet set compliance dates for this requirement) and Mexico will be adopting the ABNS model by the year 2011 (this is the specialist professional nurse in the Mexican education process). Canada has also adopted the requirement for the BSN for entry-to-practice for the year 2000, at which time it is anticipated that certification requirements will be changed accordingly.

The United States is the only country thus far that has two levels of certification, one for basic nursing practice and one for advanced nursing practice, which is defined as master's level preparation. Canada has long range plans to develop an advanced practice level of certification. Mexico, due in part to the newness of its development of plans for formal certification, has not moved into consideration of advanced level certification.

The United States is the one of the three countries that has in place a mechanism for approval of certifying organizations. This approval is conferred by the American Board of Nursing Specialists.

The process for recertification is perhaps the least congruent among the countries. For Mexico, this is only a future projection, as the first certifying exams are only in the planning stages. In Canada, the interval for recertification is every five years and the process may be accomplished either by re-examination or continuing education credits. In the United States, this is a very varied process. Organizations have different intervals (usually between 3-5 years) for recertification as well as different processes; some organizations require re-examination, while others offer options (e.g., re-examination or continuing education credits). This lack of homogeneity might be seen as one of the areas in which the United States might focus attention on developing congruity between and among certifying organizations.

Similarities and Differences in Nursing Specialty Certification in Canada, Mexico and the United States

Aspect	Canada	Mexico	United States
Definition of certification (voluntary, formal, standard of competence)	+	+	+
Purpose of certification (promote safe service to health care consumers and recognition of nurse for meeting predetermined standards)	+	+ (more focus on quality assurance)	+
Definition of specialty (a nursing subsystem that possesses a distinct body of knowledge, practice standards, education, research)	+	+	+
Level of certification • **Basic** • **Advanced**	+ + (long range plan for advanced certification)	+	+ +
Certifying organization	+	+	+
Certifying programs	CNA (private)	CNE (private)	Several (private)
Number of certified specialties	7 (present) 4 (additional for year 2000)	8 (proposed) 7 (subspecialties)	92
Eligibility requirements for certification:			
1. Baccalaureate degree in nursing	(to be reviewed in year 2000)	Up to year 2010, both technical and professional nurses will be certified. Starting in 2011, only professional nurses will be certified.	+/– (some programs)
2. Master's Degree	–	–	– (recommended for advanced practice)
3. Registration, license, cédula	+	+	+
4. Education specialty	–	+	+/– (some programs)
5. Experience in specialty	+	+	+
6. Submit application	+	+	+
7. Letter of reference	+	+	+/– (some programs)
Requirements for certification **Pass certification examination**	+	+	+

+ = exists

Aspect	Canada	Mexico	United States
Eligibility requirements for recertification:			
1. Active certification	+	+	+
2. A period of experience (either as full time, or as equivalent in part time)	+	+	+
3. Letter of reference	+	+	+/– (some programs)
4. Meet continuing education requirements, or pass specialty certification examination	+	+	+
5. Submit application for recertification	+	+	+
Number of nurses certified on or before 1995	2677 (1 percent of 280,000 nurses)	0 (out of 184,950 nurses)	350,000 (15 percent of 2.2 million nurses)
Recertification periodicity	5 years	5 years	2 to 5 years according to specialty
Program evaluation	+	+	+/– (some programs)
Evaluation of certification on health outcomes	–	+	–

+ = exists

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Recommendations

Nursing Specialty Certification in Canada, Mexico and the United States

Canada, Mexico and the United States recognize the importance for each of the three countries to meet their health care needs, while providing support to each other to foster the advancement of the nursing profession. The following recommendations imply an ongoing trilateral commitment among Canada, Mexico and the United States.

1. To identify the resources necessary to implement the Mexican certification program plan.
2. To seek funding opportunities (e.g., government, professional associations, corporations, health care agencies) to implement and evaluate the certification program plan of Mexico.
3. To establish a trilateral information system to monitor nursing and health care developments in an effort to enhance informed decision making.
4. For nursing organizations in all three countries to further explore the application of a nursing framework to classify nursing specialties/subspecialties (e.g., ICN model).
5. To investigate innovative means of evaluating nurse competency.
6. To develop guidelines establishing reciprocal agreements among certification organizations.
7. To encourage trilateral research on the impact of certification on health outcomes.

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Summary & General Recommendations

Action Plan for Phase Two of the Trilateral Initiative for North American Nursing

The preceding document represents Phase One of an unparalleled, collaborative effort among nurses from Canada, Mexico and the United States. Participants in this complex process, which produced an assessment of North American nursing standards, worked diligently to overcome differences in language, culture and distance as they worked toward achieving the comprehensive goals set forth by the Trilateral Initiative for North American Nursing. By developing a systematic process of assessment and review, under the oversight and coordination of the Commission on Graduates of Foreign Nursing Schools (CGFNS), the Trilateral Initiative made important strides toward developing mutually acceptable nursing standards throughout the continent.

The Initiative assessed nursing standards in four areas: education, education program approval and accreditation, licensure/registration, and specialty certification. Assessments identified the similarities and differences among the three countries in numerous aspects of these four areas and developed recommendations for establishing mutually acceptable standards that would advance the nursing profession across North America.

In Part One of this document, Standards of Nursing Education, recommendations focused on using a collaborative trilateral process to conduct a more detailed comparative analysis in each country of the standards that regulate nursing education and guide the development of nursing education programs and to facilitate the attainment of a nursing regulatory role in Mexico. Further proposed was an analysis of future trends and their expected impact on education standards and nursing programs in the years ahead.

Recommendations for nursing education program approval and accreditation, discussed in Part Two, focused on continuing a collaborative trilateral process to conduct a more detailed comparative analysis of the standards that guide the development of excellence in nursing education through accreditation programs and national nursing standards; establishing strategies for decreasing differences among the countries in terms of accreditation of the quality of educational programs; and strengthening the exchange of information among those in charge of the approval and accreditation processes in each country.

Recommendations for licensure/registration of nurses and standards of practice, analyzed in Part Three, identified important opportunities for mutual learning and possible action regarding licensure/registration and standards of practice. Key recommendations synthesized from these opportunities include developing mutual understanding of the similarities and differences among the countries' regulatory standards of practice, including ongoing competence, and of their relationship to ensuring safe practice in the context of each country's health care system.

In Part Four, Nursing Specialty Certification, the Trilateral Initiative recommended investigating innovative means of evaluating nurse competency; developing guidelines to establish reciprocal agreements among certification organizations; conducting trilateral research on the impact of certification on health outcomes; and exploring a nursing framework to classify nursing specialties in all three countries. Also recommended was a trilateral commitment to identify the resources necessary to implement the Mexican certification program plan and to seek funding opportunities for such implementation and evaluation.

All three countries recognized the importance of providing support to each other to foster the advancement of the nursing profession. By comparing and contrasting nursing standards across the continent and by developing these comprehensive recommendations, the Trilateral Initiative has achieved the three goals it set forth to accomplish: it has laid the foundation for developing mutually acceptable standards for education, education program approval and accreditation, licensure/registration, and specialty certification among Canada, Mexico and the United States, in order to advance the nursing profession across North America; it has established a viable, lasting network of key nursing organizations and professionals across North America; and it has created a methodology and model for other professional groups to develop processes for appraising their own standards and recommending changes in accordance with NAFTA

guidelines. Achieving these goals marks the successful culmination of Phase One.

As the Trilateral Initiative participants developed the recommendations for specific topics discussed above, they became aware of the need to develop general, project-wide recommendations to govern future phases of the Initiative as well. The following broad-based recommendations and the strategies for implementing them will form the Action Plan for Phase Two. Consistent with its leadership during Phase One, CGFNS, with its coordinating council of core group facilitators and representatives from Mexico, will provide continuity and ensure implementation of the general recommendations. These recommendations represent a mandate for the future and outline the exciting work ahead as the Trilateral Initiative moves forward to Phase Two.

Action Plan for Phase Two

Establish a more comprehensive, comparative data base of entry level nursing education standards, educational pathways/levels, processes and competencies, as well as standards of approval and accreditation, within and among the three countries.

- Conduct a detailed, comparative analysis of:
  - the standards for regulation/approval of nursing education programs comparing the standards of each American state, Canadian province, and Mexican Federal Government (SEP) and University Standards.
  - the accreditation systems and national nursing education standards that guide the development of excellence in nursing education.
  - The differentiated competencies achieved in the various nursing education pathways/levels for entry into practice.

Demonstrate and evaluate the impact of nursing regulation on the public's health, safety and welfare.

- Develop a trilateral process to demonstrate linkages between nursing regulatory processes and protection of the public.
- Develop a trilateral process to identify the relationship between standards of nursing practice and ongoing nursing competency.

Evaluate the impact of nursing specialty certification on health outcomes.

- Implement the ICN framework to classify nursing specialties/subspecialties in all three countries.
- Conduct trilateral, multidisciplinary research on the impact of certification on health outcomes.

Establish mechanisms to monitor developments in nursing and health to enhance trilateral decision-making.

- Establish a trilateral, coordinated Information System with the following characteristics: culturally and linguistically accessible, centralized and ongoing, current, and technologically innovative.
- Strategically monitor and analyze societal and health trends and their impact on North American nursing.

Establish a comprehensive, trilateral agenda.

- Identify research opportunities and priorities emerging from the Trilateral project.
- Establish coalitions to conduct research activities.
- Disseminate pertinent research findings to federal and state/provincial governments and other key stakeholders to influence health and nursing policy decisions.

Glossary of Terms

Trilateral Initiative for North American Nursing

Accreditation of Nursing Programs

A voluntary review and assessment process whereby educational institutions and/or programs are recognized for quality when reviewed against predetermined standards or criteria established and measured by peers. Institutional accreditation may be national or regional in scope and generally covers all programmatic offerings by the institution. Accreditation of nursing programs is normally carried out by non-governmental agencies or professional associations. Accreditation is designed to assist in the improvement of schools/programs, to maintain and enhance the quality of education, and to contribute to the improvement of nursing practice.

Advanced Nursing Practice

Generally used to describe nursing knowledge and skills acquired beyond those attained in one's basic nursing education. Reflects achievement of an additional minimum standard, and may result in legal authority to perform procedures beyond the basic scope of nursing practice. Completion of a specialized educational program, for example, at master's degree level, and participation in more complex clinical experiences are increasingly considered prerequisites for full participation in advanced nursing practice. Designation as an advanced practice nurse can require either licensure or certification depending on the regulations of a state or province.

Approval

A legal process for the review of educational programs to ensure compliance with minimum nursing education standards. Approval is a mandatory process for schools/programs. In the United States, the standard-setting/approval entities are governmental agencies. In Canada, provincial and territorial governments have entrusted approval to provincial or territorial nursing associations or governmental regulatory bodies. In Mexico, the federal government through the Public Education Secretariat (SEP) or universities, as delegated by the government, approves nursing education programs.

Certification

Certification is a process that is usually voluntary, formalized, has set standards for meeting specialty criteria, and has as its outcome the assessment of competence in the field of nursing for which certification is sought. Certification, most often national in scope, is administered by non-governmental professional associations or certifying agencies.

Community Service

Community service is temporary work done by professionals and students for the benefit of society and State (Article 53 of the Mexican Regulation of the Fifth Constitutional Article on the Practice of Professions). Community service is viewed as the final academic stage in the nursing career. It is the product of interaction between the educational and healthcare sectors and has two goals: 1) to deliver continuous and organized health services to all Mexican communities, especially to the poorest communities, and 2) to provide an opportunity for students to apply their newly acquired skills under supervision. Community service can be done only after earning all required academic credits. During the course of community service, the student is periodically visited by supervisors from both the educational institution and the healthcare institution, in order to receive advice and support for his/her professional practice. The student must submit a report to both the healthcare institution and the educational institution every three months and a final report stating all work accomplished.

At the conclusion of community service, the healthcare institution will deliver an official document to the student stating that he/she has complied with this academic requirement. The student will then be able to obtain a professional degree. Thus, community service is an indispensable prerequisite for a professional title or degree in nursing.

Criterion

The term criterion refers to an objective, measurable qualitative or quantitative indicator. The terms "criterion" and "standard" are frequently used interchangeably.

First-level Nurse

An historic term used by the International Council of Nurses (ICN) to denote a person who has attained the highest level of basic general nursing education in his or

her country. In Canada, the title Registered Nurse is used in all provinces/territories except Quebec where the term is Infirmier/Infirmiére. In the United States, this nurse's title is Registered Nurse or Registered Professional Nurse. In Mexico, the term Licenciada en Enfermería is used. In addition, the title General or Technical Nurse, Enfermero/Enfermera, refers to the Mexican nurse who has completed nine years of basic education and a three year nursing education program.

Generalist

In Canada, Mexico and the United States, all nurses are prepared as generalists. Generalist nursing education includes theoretical course work and clinical practice in a number of distinct nursing areas, including nursing care of the adult, nursing care of children, maternal/infant nursing, and psychiatric/mental health nursing. The generalist education in Canada and the United States prepares the nurse for roles as direct care giver, coordinator of care, client advocate, and professional member. In Mexico, the education focuses on the roles of direct care giver, coordinator of care, and user of scientific knowledge.

Licensure/Registration

The process by which a government agency, or non-governmental organization that has been authorized by the government, determines that an individual who meets minimum standards may engage in a given profession or use a particular title. Also indicates to the public that the person who has been granted the license (cédula), or has been placed on the public registry, has the minimum competence needed to provide for the public's protection and is accountable for his or her practice. In Mexico, first-level nurses receive a cédula.

Nurse Practice Acts (Law on Nursing Practice in Mexico)

Legislation that establishes the regulatory structure within a jurisdiction that describes the educational preparation, licensure criteria, and the range of activities in which the nursing professional can engage. Nurse Practice Acts often include other information related to the regulation of the nursing profession within a given jurisdiction.

Regulation

A broad term that describes the methodologies by which accountability is brought to a profession and its practice, for the purpose of protecting the public.

Standards of Nursing Practice

Regulatory standards describe the minimum acceptable levels of nursing practice and serve as a guide to determine if that practice is safe and effective. Professional standards of nursing practice, that differ from and may exceed the minimum acceptable levels, also exist.

Scope of Practice

The range of activities that nurses are educated and authorized to perform. The profession defines the scope of practice, which may be codified into Nurse Practice Acts or other regulations. Nurse Practice Acts are within the authority of jurisdictions and therefore may be different from state to state, or province/territory to province/territory within each country.

Second Level Nurse

An historic term used by the International Council of Nurses (ICN) to denote the nurse who gives nursing care in cooperation with and under the supervision of a first-level nurse. In Canada, a second level nurse holds the title Registered Practical Nurse, Licensed Practical Nurse, Certified Nursing Assistant or Registered Nursing Assistant. In some Canadian jurisdictions, a second level nurse is one who performs as an autonomous professional, but whose basic general nursing education is less than the minimum required of a first-level nurse. In the United States, the second level nurse's title is Licensed Vocational Nurse or Licensed Practical Nurse.

Stakeholders

Those whose support is necessary to effectively influence health policy, e.g. governments, health care delivery systems, consumers, unions, educational systems, other professionals, and special interest groups.

Specialty Practice of Nursing

In Canada, Mexico, and the United States, nurses are first educated as generalists. Subsequently, they may receive additional education in one of a number of post-basic specializations, e.g., clinical nurse specialist in oncology nursing, gerontological nursing, or a nurse practitioner, such as a family nurse practitioner (See also Advanced Nursing Practice). In many other countries, nurses are educated initially in a basic specialty, e.g., child care nurse, mental health nurse, and not for the full scope of nursing practice.

Standard

Represents an agreed-upon level of performance. When using a standard as a basis of evaluation, actual performance is measured against the desirable and achievable level of performance (standard). There are three types of standards generally used in measurements: structure, process, and outcome.

Organizations/Associations

The following list is representative of the organizations and associations referred to throughout the monograph. In order to ensure easier reading, the organization/association name has been written in the language native to its country of origin, with the acronym (if available) in parenthesis and the language translation in italics.

Canada

- Canadian Association of University Schools of Nursing (CAUSN)
- Canadian Nurses Association (CNA)
- Canadian Nurses Association Testing Services (CNATS)
- College of Nurses of Ontario

United States

- American Association of Colleges of Nursing (AACN)
- American Board of Nursing Specialties (ABNS)
- American Nurse Association (ANA)
- American Nurses Credentialing Center (ANCC)
- Commission on Graduates of Foreign Nursing Schools (CGFNS)
- Educational Testing Service (ETS)
- Joint Commission on Accreditation of Health Care Organizations (JCAHO)
- National Council of State Boards of Nursing (NCSBN)
- National League for Nursing (NLN)
- Nursing Organization Liaison Forum (NOLF)
- National Specialty Nursing Certification Organization (NSNCO)

Mexico

- Ascociación Mexicana de Enfermeras (AME)
  Mexican Nurses Association
- Asociación Mexicana de Licenciados en Enfermería (AMLE)
  National Association of Bachelors in Nursing
- Asociación Nacional de Escuelas de Enfermería
  National Association of Nursing Schools
- Asociación Nacional de Unversidades e Instituciones De Educación Superior (ANUIES)
  National Association of Higher Education Institutes
- Colegio Nacional de Enfermeras, A.C. (CNE)
  National College Of Nursing
- Comisión Interinstitucional Nacional de Enfermería
  National Nursing Interinstitutional Commission
- Comisión Interinstitucional para la Formación de Recursos Humanos para la Salud (CIFRHS)
  National Interinstitutional Commission for the Preparation of Health Resources
- Comité Mexicano para la Practica Internacional de Enfermería (COMPIE)
  Mexican Committee for the International Practice of Nursing
- Desarrollo Integral para la Familia (DIF)
  Family Integral Development System
- Dirección General de Profesiones (DGP)
  General Professions Directorate
- El Sistema Nacional para la Acreditación y la Certificación de Enfermería (SNACE)
  The National Nursing Accreditation and Certification System
- Escuela Nacional de Enfermería y Obstetricia de la Universidad Nacional Autónoma de México (ENEO)
  National School of Nursing and Obstetrics at the National Autonomous University Of Mexico
- Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería (FENAFEE)
  National Federation Of Nursing School Associations
- Instituto Mexicano del Seguro Social (IMSS)
  Mexican Social Security Institute
- Profesíonistas Técnicos y No-Medicos
  Non-Physicians and Technical Professionals Committee
- Secretaría de la Salud Pública (SSA)
  Public Health Secretariat
- Secretaría de Educación Pública (SEP)
  Public Education Secretariat

- Seguridad Social al Servicio de los Trabajadores del Estado (ISSSTE)
  Social Security and Services Institute for Government Workers
- Universidad Nacional Autónoma de México (UNAM)
  National Autonomous University of Mexico

Switzerland

- International Council of Nurses (ICN)

Project Participants and Contact Resource Persons

The following participants served on the four core groups charged with preparing the assessment of the four topic areas for Phase One of the Trilateral Initiative for North American Nursing:

Standards for Nursing Education

Facilitator:

Margaret (Pegi) Earle, RN, BN, MScN	Canadian Nurses Association

Core Group Participants:

Canada:

Penny K. Ericson, RN, MScN	Canadian Association of University Schools of Nursing

Mexico:

Lic. Ma. de Jesús Elena Velásquez G.	Colegio Nacional de Enfermeras, A.C.
Lic. Irma Julieta Gómez Flores	Colegio Nacional de Enfermeras, A.C.
Lic. Esther C. Gallegos	Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería

United States:

Geraldine D. Bednash, PhD, RN, FAAN	American Association of Colleges of Nursing
Joyce Murray, EdD, RN, FAAN	National League for Nursing

Contact (Resource) Persons:

Dr. Juan Casillas García de León	Asociacion Nacional de Universidades e Institutos de Enseñanza Superior
Dr. Juan Ramón de la Fuente Ramírez	Departamento Ministerial de Investigación de Salud e Instrucción
Fernando de Mateo Venturini	Secretaría de Industria, Comercio y Trabajo
Linda Burns-Bolton, DrPH, RN, FAAN	National Black Nurses Association
Helen Castillo, PhD, RN	National Association of Hispanic Nurses
Alice M. Tse, PhD, RN	W.K. Kellogg Community Partnerships Leadership Development Program

Nursing Education Program Approval and Accreditation

Facilitator:

Wendy McBride, MA	Canadian Association of University Schools of Nursing

Core Group Participants:

Canada:

Marlene Smadu, RN, EdD	Canadian Nurses Association

Mexico:

Enf. M.A.B. Leticia Moriel Corral	Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería
Ma. del Carmen Arancón García	Colegio Nacional de Enfermeras, A.C.
Lic. Sara Alicia Ponce de León Muñoz	Colegio Nacional de Enfermeras, A.C.

United States:

Julia E. Gould, RN, MS	Georgia Board of Nursing
Betty J. Horton, CRNA, MA, MSN	Council on Accreditation of Nurse Anesthesia Educational Programs
Sandra Lewinson, EdD, RN	National League for Nursing
Joyce Murray, EdD, RN, FAAN	National League for Nursing
Ildaura Murillo-Rohde, PhD, RN, CS, ND, FAAN	National Association of Hispanic Nurses

Contact (Resouce) Persons:

Lic. Diana Cecilia Ortega Amieva	Subsecretaría de Educación Superior
Lic. Juana Rocha Cervantes	Colegio Nacional de Enfermeras, A.C
Lic. Bertha Delgado Choreno	Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería
Maricel Manfredi, RN, MSN	Pan American Health Organization

Licensure/Registration and Standards of Nursing Practice

Co-Facilitators:

Jennifer Bosma, PhD	National Council of State Boards of Nursing
Carolyn Hutcherson, MS, RN	National Council of State Boards of Nursing

Core Group Participants:

Canada:

Elisabeth Scarff, LL.B	College of Nurses of Ontario

Mexico:

Lic. Silvia de la Fuente Rocha	Colegio Nacional de Enfermeras, A.C.

United States:

Cheryl Peterson, MSN, RN	American Nurses Association
Sally Ruybal, PhD, RN	National Association of Hispanic Nurses

Contact (Resource) Persons:

Elaine Zinman-Madoff	Gouvernement du Quebec Ministere de Affaires Internationales de l'Immigration et des Communautes Culturelles Service des Equivalences
Marjorie Beyers, PhD, RN, FAAN	American Organization of Nurse Executives
Teresa Bello-Jones, JD, MSN, RN	California Board of Vocational Nurse and Psychiatric Technician Examiners
Sandra Land, RN, MPH, PhD	Pan American Health Organization

Nursing Specialty Certification

Facilitator:

Gail Tomblin Murphy, RN, BN, MN	Canadian Nurses Association

Core Group Participants:

Mexico:

Lic. Josefina Reyes González	Colegio Nacional de Enfermeras, A.C.
Lic. Juana Jiménez Sánchez	Colegio Nacional de Enfermeras, A.C.

United States:

Janice Camp, MSN, RN, COHN	American Board of Nursing Specialties
Carolyn K. Lewis, PhD, RN	American Nurses Credentialing Center
Jane C. Rothrock, DNSc, RN, CNOR	Nursing Organization Liaison Forum

Contact (Resource) Persons:

Yves LaFortune, MEd	Canadian Nurses Association

Review Organizations

Following compilation of the four topic papers incorporating the work of the four core groups, the following organizations were afforded an opportunity to review the drafts of selected chapters and/or of the monograph and offer their comments and corrections. Acknowledgement as a review organization does not indicate endorsement of the final document.

Canada

Canadian Nurses Association (CNA)

Canadian Nurses Association Provincial/Territorial Representatives:

- Registered Nurses Association of British Columbia
- Alberta Association of Registered Nurses
- Saskatchewan Registered Nurses Association
- Manitoba Association of Registered Nurses
- Registered Nurses Association of Ontario
- Nurses Association of New Brunswick
- Registered Nurses Association of Nova Scotia
- Nurses Association of Prince Edward Island
- Association of Registered Nurses of Newfoundland
- Northwest Territories Registered Nurses Association
- Yukon Registered Nurses Association

Canadian Association of University Schools of Nursing (CAUSN)

College of Nurses of Ontario

Ordre des Infirmiéres et Infirmiers du Québec

Mexico

Asociación Mexicana de Licenciados de Enfermería (AMLE)

Colegio Nacional de Enfermeras, A.C. (CNE)

Federación Nacional de Asociaciones de Facultades y Escuelas de Enfermería (FENAFEE)

United States

American Association of Colleges of Nursing (AACN)

American Board for Occupational Health Nurses

American Nurses Association (ANA)

American Nurses Credentialing Center (ANCC):

- ANCC Board on Certification: Community Health Nursing Practice
- ANCC Board on Certification: Gerontological Nursing Practice
- ANCC Board on Certification: Maternal-Child Nursing Practice
- ANCC Board on Certification: Medical-Surgical Nursing Practice
- ANCC Board on Certification: Nursing Administration
- ANCC Board on Certification: Nursing Continuing Education and Staff Development
- ANCC Board on Certification: Primary Care in Adult and Family Nursing Practice
- ANCC Board on Certification: Psychiatric and Mental Health Nursing Practice

American Organization of Nurse Executives

Citizen Advocacy Center

Commission on Graduates of Foreign Nursing Schools

Council on Certification of Nurse Anesthetists

National Association of Hispanic Nurses

National Council of State Boards of Nursing

National League for Nursing

State Boards of Nursing:

- Arkansas State Board of Nursing
- California Board of Registered Nursing
- Georgia Board of Nursing
- Iowa Board of Nursing
- New Hampshire Board of Nursing
- Oregon State Board of Nursing
- South Carolina State Board of Nursing
- Texas Board of Nurse Examiners
- Wisconsin Department of Regulation & Licensing

Nephrology Nursing Certification Board

Nursing Organization Liaison Forum Members:

- Emergency Nurses Association
- National Certification Board for Perioperative Nursing, Inc.
- Society for Gastroenterology Nurses and Associates
- American Society of Ophthalmology Registered Nurses
- Association of Rehabilitation Nurses
- Association for Professionals in Infectious Control
- American Association of Neuroscience Nurses

Oncology Nursing Certification Corporation

Orthopedic Nurses Certification Board

Rehabilitation Nursing Certification Board

U.S. Department of Health and Human Services/Division of Nursing

Translation Reviewers

Following completion of the final draft document, the monograph was reviewed by Translation Reviewers who were both nurses and either bilingual or trilingual. These reviewers sought to compare the English, Spanish and French versions of the monograph and to highlight continuity issues among the versions. The reviewers were:

Spanish

Hector Hugo Gonzalez, PhD, RN
Professor and Chairman Emeritus
Department of Nursing Education
San Antonio College

Sally E. Ruybal, PhD, RN
Professor
School of Nursing
University of New Mexico

Mary Thompson, BScN
Public Health Nurse
Regional Municipality of Hamilton-Wentworth
Hamilton, Ontario, Canada

Anna Carias, RN
Transcultural Consultant

French

Béatrice Mullington, RN, BScN, MHA
Nursing Policy Consultant
Canadian Nurses Association
Ottowa, Ontario, Canada

Hélène Sabourin, RN, BScN, MHA
Manager of Certification
Canadian Nurses Association
Ottawa, Ontario, Canada

Trilateral Review Panel

Following the comments of the Translation Reviewers, the monograph was reviewed by a nine-member review panel organized by country of origin. Each of the three members in these country teams reviewed a separate language-version of the monograph for issues of accuracy, objectivity, and uniformity, as well as other content issues. The nine panel members included:

CANADA

Lucille Auffrey
Executive Director
Nurses Association of New Brunswick

Donna Brunskill, RN, BScN, MSA
Registrar
Saskatchewan Registered Nurses Association

Susan French, PhD, RN
Professor
School of Nursing
McMaster University

MEXICO

Lic. Rosa María Nájera
Profesor Titular "C"
Universidad Autónoma Metropolitana

Lic. Ma. del Carmen Salas Ramos
Profesor Titular "A" en la FES-Zaragoza
Universidad Nacional Autónoma de México

Margarita Navarro Salazar
E.S.P. Profesor Titular "B"
Instituto Politécnico Nacional

UNITED STATES

Elizabeth T. Anderson, DrPH, RN, FAAN
Professor and Chair
Department of Community Health & Gerontology
Director, WHO Collaborating Center for Nursing
Development in Primary Health Care
University of Texas Medical Branch-Galveston

Beverly McElmurry, EdD, FAAN
Professor and Associate Dean
Office for International Studies
Director, WHO Collaborating Center for
Advancement of Primary Healthcare
College of Nursing
University of Illinois-Chicago

Robert Piemonte, EdD, RN, CAE, FAAN
Executive Director (retired)
National Student Nurses Association

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CANADA

All Languages, Ltd., Ottawa, ON

Irma Masferrer, Gloucester, ON

Gilles Renaud, Toronto, ON

MEXICO

Angelina Covarrubias
World Class, Garza, Garcia, NL

Francisco Resendiz Gonzalez, Mexico City

UNITED STATES

Sylvia Anador, Chicago, IL

Sonia Barinas
Barinas Translations, San Antonio, TX

Maria Zinola
Interpreters International and Translations
Kew Gardens, NY

3600 Market Street, Suite 400
Philadelphia, PA 19104-2651 U.S.A.

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